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Chemist&Druggist
The Newsweekly for Pharmacy

C&D

11 February 2006

Alliance-Boots merger given a qualified 'yes'

Oxygen service chaos: warnings were not heeded

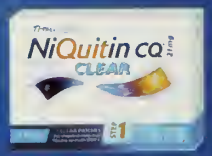
Numark ditches its 'sub-optimal' wholesalers

Bringing bird flu up to date: how pharmacy fits in

...And they don't even need an appointment

Each time your customer gets NRT from you, you give them the opportunity to reduce their chance of premature death.[1] By recommending NiQuitin CQ® 21mg Clear patch to smokers you can help 6 out of 10 smokers stay quit for 4 weeks,[2] improving their long term health prospects.

Help your customers quit with NiQuitin



nicotine

NiQuitin CQ 21, 14, 7mg Transdermal Patches, NiQuitin CQ Clear 21, 14, 7mg (nicotine). See SPC for full information. Opaque or transparent transdermal patches 21mg, 14mg, 7mg nicotine (Steps 1, 2, 3) for relief of nicotine withdrawal symptoms during smoking cessation. **Dosage:** Adults; ≥18 years: 1 patch/day. Step 1 for 6 weeks, then Step 2 for 2 weeks, then Step 3 for 2 weeks. 10 cigarettes/day; Step 2 for 6 weeks then Step 3 for 2 weeks. Apply to fresh, clean, dry skin) once daily. **Contraindications/precautions:** Hypersensitivity, [illegible] disease, severe renal/hepatic impairment, hyperthyroidism, diabetes, phaeochromocytoma, dermatitis. **Side effects:** Local rash, itching, burning, tingling, numbness, swelling, pain, urticaria, heaviness. Depression, irritability, anxiety, [illegible] restlessness, mood lability, drowsiness, impaired concentration, insomnia, [illegible] disturbance. Allergic reactions, abnormal dreams, nausea, vomiting, dry mouth, [illegible] headache, dizziness, palpitations, tachycardia, tremor, dyspnoea, pharyngitis, cough, arthralgia, myalgia, sweating, chest pain, fatigue, malaise, flu-like symptoms. See SPC for full details. **Pregnancy/lactation:** Try without nicotine replacement therapy. Medical assessment of risk/benefit if necessary. GSL **PL** 00079/0347, 0346, 0345, 0356, 0355 & 0354. **PL holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Pack size and RSP:** All strengths 7 patches £17.49; Step 1 only 14 patches £32.95. **Date of revision:** December 2005.

References: 1. ABC of Smoking Cessation 2004, Blackwell Publishing. **2.** TNSG, JAMA, 1991; **266**: 3133-3138.

GlaxoSmithKline
Consumer Healthcare

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Contents

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Asha Fowells, *MRPharmS*
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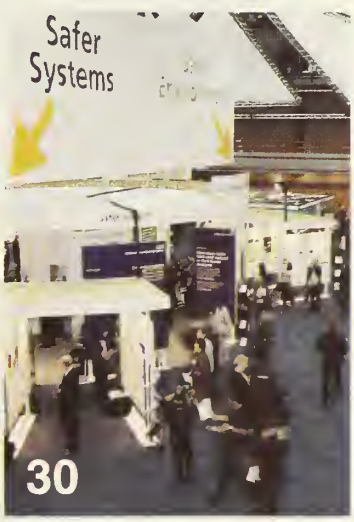
This week

Pharmacy update



Regulars

Features

OFT clears Boots Alliance merger

by Max Gosney

Alliance UniChem and Boots can continue their merger provided they sell off about 100 stores, the Office of Fair Trading ruled this week.

Boots and AU must resolve competition concerns among pharmacies in certain locations or the £7.6 billion deal will be referred to the Competition Commission, the OFT warned.

Vincent Smith, competition enforcement director at the OFT, said: "This merger raises the realistic prospect of a substantial lessening of competition in around 100 local areas. However, Boots has offered divestment undertakings for all of these areas and the OFT is satisfied that these will address its concerns."

The OFT was unable to confirm the locations of the affected stores. The proposed merger raised no competition issues around AU Boots' wholesaling business, it added.

Boots welcomed the OFT ruling and said it would work closely to resolve the competition concerns. A spokesman said: "It's a significant step forward to creating a pharmacy-led group. The competition concerns surround a mixture of Boots and AU stores, which are likely to be sold."

Boots' shareholders could get to vote on merger proposals "late this summer" after the OFT's concerns had been satisfied, stated the company.

However, the proposed merger could still be sidelined by rival buyers, according to city analysts. Barclays stockbrokers confirmed that private equity firms Apax Partners, CVC Capital and Texas Pacific could launch a bid for Boots, as reported in the *Sunday Times*.

Director of investment strategy at the firm, Hilary Cook, said: "Just because the merger has been given clearance it doesn't mean it will go through. The company is cash rich and very attractive to private equity buyers. But, once it merges with AU it's a bigger mouthful."

Boots could struggle to suppress any offer by a private equity buyer, predicted Ms Cook.

"This is a nil premium merger with AU so shareholders are not being offered a big carrot to accept it. But a private equity bid will be paying high value on shares," she said.

One of the companies linked to Boots, Apax Partners, said it "could not confirm or deny" bid reports.

WHOLESALING

Numark ends supply contracts

Numark has clashed with UniChem and Mawdsleys after it served six months' notice on their contract to supply around 180 member pharmacists.

Numark said it had sacked the duo for poor support of the symbol group and its brand. However, the wholesalers claimed Numark had acted in the interests of parent company and wholesaler, Phoenix rather than its members.

Mawdsleys' managing director Ian Brownlee said: "Such a well respected organisation deserves better than to have become the marketing arm of a foreign owned regional wholesaler."

But Numark managing director Simon Colebeck dismissed the wholesaler's comments as "utter nonsense" and said that the provision of Numark products was "sub-optimal" in some instances.

"The terms of the supply contract say you should promote Numark goods and services as the primary offering. Over the past five years we've made several warnings to Mawdsleys and UniChem about this. They've been playing games and the snooze button on the alarm clock has been switched off." **MG**

PRACTICE

Chaotic start to new DoH oxygen supply service

Pharmacists have been left to pick up the pieces after the companies delivering the new home oxygen service experienced difficulties rolling out the service since its launch last Wednesday.

GPs have issued prescriptions instead of filling out the new oxygen ordering form because they have been unable to contact the new suppliers, according to PSNC information services head Lindsay McClure.

In light of the chaos, the DoH has advised GPs to issue a prescription if a patient requires immediate supplies. It added that "emergency communications" had been sent to PCTs and that pharmacists could continue to provide cylinder oxygen and receive payment under current NHS arrangements where they had agreed to do so.

The Welsh Assembly Government also said it would reimburse prescriptions dated after February 1, but will confirm a 'cut off' date for reimbursement next week.

Primary Care Contracting, which is co-ordinating the handover to the new service, confirmed that there had been problems with it, and blamed GPs for sending in non-urgent or incomplete oxygen request forms.

"Community pharmacists will be extremely angry that, when none of their requests for support related to stopping the old arrangements have yet been met, they are expected to pick up all the pieces," Sue Sharpe, PSNC chief executive, said.

Similarly, John D'Arcy, NPA chief executive, added: "Having been told they are no longer needed to provide an oxygen therapy service, community pharmacists are now expected to bale out the DoH. The NPA has always been concerned about the possible implications of a 'big bang' transition. The concerns appear to be well founded."

The DoH said it was "aware some areas are experiencing difficulties" with the home oxygen service. It said this was due a to number of factors including "high number of orders received, whether or not the oxygen is needed immediately". **AC**

Supplied by Dollar Rae

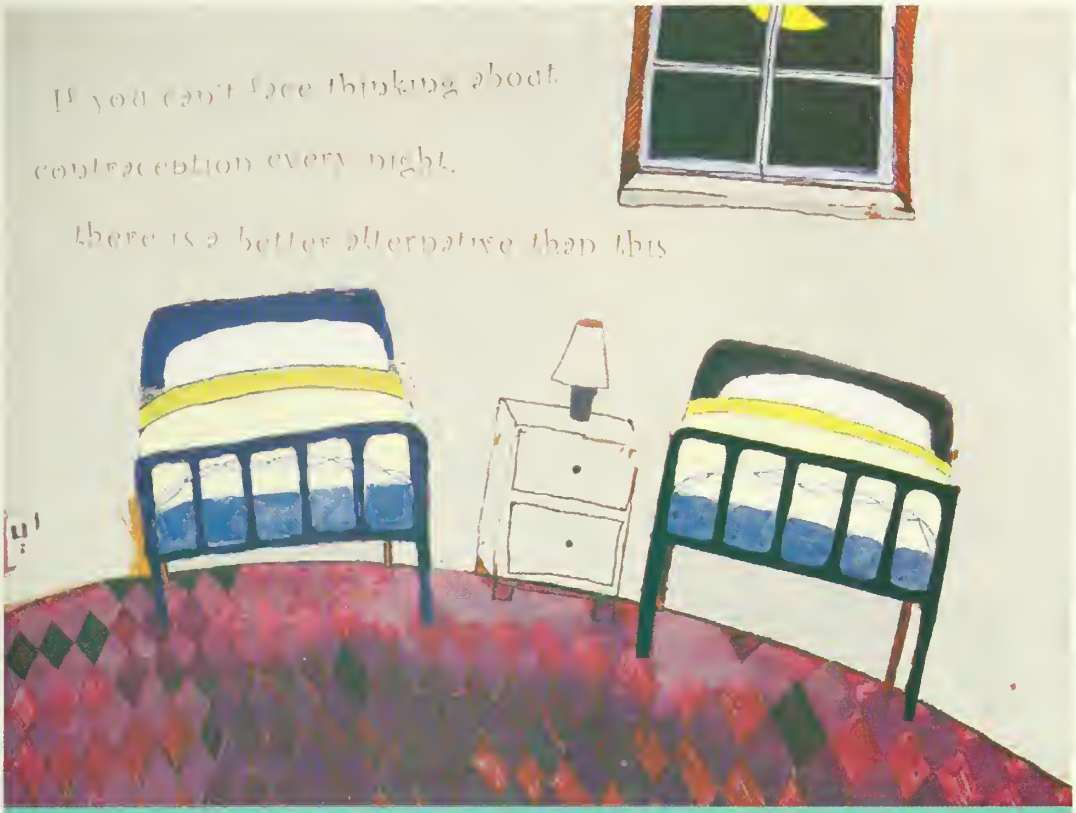
Lawrence Sprey: "Clinical genocide"

Your Views

"The situation has been hopelessly mishandled. The DoH thought this was just a delivery job... and has underestimated the skills, knowledge and hard work being done by community pharmacists. They acted like a brick wall... they weren't prepared to listen and now it isn't working."
Bob Gartside, pharmacist, Wales

"It's clinical genocide by the Government. These old people cannot breathe but it's taking four hours to four days to deliver oxygen. People are going to die. I don't know who is responsible but someone should lose their job for this."
Lawrence Sprey, Ashtons Late Night Pharmacy, Brighton

"We seem to be doing as much oxygen as before. I can't say I am surprised. We have been warning that this might happen for months."
Martin Bennett, Associated Chemists (Wicker), Sheffield



Long-acting reversible contraception (LARC) is the focus of this year's Contraceptive Awareness Week, run by the fpa (formerly the Family Planning Association). During the event, which runs from February 13 to 19, the charity is calling on clinics, GPs and pharmacists to be more proactive in explaining the full range of contraceptive options to women. Anne Weyman, fpa chief executive, said: "Pharmacists are well placed to initiate these discussions face to face with customers and through promoting LARC methods in leaflet stands at the counter." Campaign materials, including the postcard pictured above, are available at *www.fpa.org.uk*

POLITICS

MURs 'not as practical as they could be' claims MP

Paul Burstow MP feels that the DoH has no clear strategy to promote the benefits of MURs

by Caroline Stocks

The way medicines use reviews are being conducted means they are "not as practical as they could be", an MP has claimed.

Questions over where funding for MURs is going should also be asked, Liberal Democrat health spokesman Paul Burstow told *C&D*.

The Government has allocated £39 million for conducting MURs for 2005-06, with each pharmacy allowed to complete a maximum of 250 reviews. So far 33,500 reviews have been completed by pharmacies.

Mr Burstow said the number of expected MURs and the number conducted was "way off".

"The expectation was in the first six months of the new contract there would be one million and two million after one year. We are way off the numbers that were anticipated and funded," he said. "The real concern is what will happen to the money allocated for this purpose."

Mr Burstow said MURs are a "useful tool" for taking a time-consuming task from GPs and giving it to pharmacies to complete. "However, I think the way MURs are operating, they aren't as practical as they could be," he said.

"The number expected to be done hasn't been done. We should be asking why and what can be done. We should also be asking for some assurance that the money set aside for them will not be wasted for deficit management."

Mr Burstow also criticised the way the public are being told about the benefits of MURs.

Although the Department of Health has spent over £58,000 to promote MURs to the public, Mr Burstow said there was no clear strategy to communicate the benefits of MURs.

CONFERENCE

New frontiers

A conference promoting the UK pharmacy market to US companies will take place next month.

A collaboration between the Company Chemists' Association and the US National Association of Chain Drug Stores, New Frontiers consists of seminars, networking opportunities and pharmacy visits.

The event will run from March 19-22 at the Marriott Hanbury Manor Hotel and Country Club in Ware, Hertfordshire. For more information, contact Georgina Craig on 01908 488818 or see *www.thecca.org.uk*

Inbrief

Nucare's MUR aid

Nucare has developed a flowchart to help its pharmacists carry out medicines use reviews.

The chart, published in Nucare's February newsletter, highlights medicines issues such as: untreated indications; unnecessary therapies, ADRs, therapy choices and compliance issues. Nucare has also developed a template for completing MUR action plans.

£2m for MS drugs

Northern Ireland is allocating an additional £2 million over the next two years to allow over 160 people to start treatment with drugs for multiple sclerosis. Health minister Shaun Woodward said the extra funding was intended to eliminate the waiting list for disease-modifying therapies by March 2008.

Substance misuse

The Royal College of General Practitioners Wales is offering free training in substance misuse. The course includes e-modules, distance learning and face-to-face learning.

For more information :

E-mail: *welshc@rcgp.org.uk*
http://tinyurl.com/9s43r
Tel: 02920 504604

Nurofen patches

We have been asked to point out that Nurofen Heat Patches are Class IIa medical devices, and not Class I as reported in the February 4 issue of *Over The Counter* (p27) due to incorrect information being supplied. See also p26 in this week's *C&D*.

Newsdesk:
01732 377688

Smartcards top agenda at ETP contractors' event

by Max Gosney

Smartcards are among the top ETP concerns for pharmacists in Hampshire, an IT workshop organised by the local pharmaceutical committee has revealed.

Contractors quizzed a panel of IT experts on registration, issuing, and day-to-day use of the technology at the event hosted by Hampshire & Isle of Wight LPC in Southampton last week.

Common areas of confusion included whether pharmacists could share smartcards and whether restrictions would apply to contractors, who also locum.

Mid-Hampshire PCT's head of medicines management, Nicola Davey, responded: "For now, pharmacists including locums will be issued with one smartcard. In the longer term when the smartcards are issued you will have roles given to you that might say you're a pharmacist and a locum, who also works in a hospital. The smartcard will reflect the range of access that you need."

Do IT: pharmacists can't afford to miss out on ETP, say Nicola Davey and Patrick Leppard

Over 1,500 local pharmacists could receive the cards by April this year, predicted Mike Holden, conference organiser and chief officer of Hampshire & IoW LPC.

Despite some teething troubles, ETP will be key to pharmacy's future success, claimed Hampshire & IoW LPC deputy chairman Patrick Leppard. "ETP will allow us closer access to patient care records in the future. If we're going to take on more clinical roles and do our jobs better then we need to be part of this."

Over 130 pharmacy staff, PCT workers and seven system suppliers attended the event, which aimed to offer hands-on information and assistance with ETP.

RETAILING

Tesco takes medicines use review lead

Tesco pharmacists have carried out over 14,000 medicines use reviews since the service was launched last summer, the supermarket firm has revealed.

Pharmacy staff had "embraced" the challenge of extra healthcare services, reported superintendent pharmacist, Penny Beck.

customers like MURs because it shows we are taking an interest

"We're delighted with our successful delivery of thousands of MURs and feel it is a reflection of the expertise of our staff. Our pharmacists said they found MURs tricky at first but picked it up very quickly. It's about being proactive," she said.

Tesco aims to complete over 200 MURs in each of its 200 in-store pharmacies, taking it to the 40,000 mark, stated Ms Beck.

The supermarket firm reported problems using "cumbersome" MUR forms. But overall the service was a success, said Val McFarlane, a pharmacy assistant at Tesco in Aldershot.

"We've got very involved with our customers and it makes it easier to approach them over MURs. They like it because we are taking an interest," she said.

Currently pharmacies in England and Wales have carried out around 30,000 MURs, according to Government figures.

● Tesco could expand its pharmacy portfolio under control of entry exemptions, the firm's pharmacy chief has confirmed.

Pharmacy superintendent Penny Beck said: "We know our customers want pharmacies in stores and we want to open more. But the regulations are preventing us to some extent."

The supermarket firm confirmed it could set up stores under the 100 hour per week opening exemption to fulfil its growth plans. **MG**

RETAILING

Guide to improving packaging

A guide to reducing safety problems by improving the design of medication packaging has been published.

The National Patient Safety Agency and the Helen Hamlyn Research Centre have created the guide to encourage clearer labelling of medicines.

The NPSA estimates 900,000 adverse events are recorded each year, with a third of these caused by confusion over packaging and labelling instructions.

It is hoped the guide, which looks at safety problems associated with blister packs, packaging and pharmacy labels, will cut the level of errors and offer the basis for best practice. **CS**

Nicorette (nicotine) Patch Product Information.

Presentation: Transdermal delivery system available in 3 sizes (30, 20 and 10cm²) releasing 15mg, 10mg and 5mg of nicotine respectively over 16 hours. **Uses:** Relief of nicotine withdrawal symptoms as an aid to smoking cessation. **Dosage:** Adults (over 18 years): Patients should stop smoking and refrain from using any other nicotine products. The patch should be applied to the skin on the hip, upper arm or chest in the morning and removed at bedtime. Application should be limited to 16 hours per day. Initially one 15mg patch daily for 8 weeks. Dose should be reduced to 10mg for 2 weeks and then 5mg for a further 2 weeks. If abstinence is not achieved at 3 months, further courses may be recommended. Adolescents (12 to 18 years): As per adult, but duration of therapy should not exceed 12 weeks without consulting a healthcare professional. Under 12 years: Not recommended. **Contraindications:** Hypersensitivity. **Precautions:** Erythema may occur. If severe or persistent, discontinue treatment. Unstable cardiovascular disease, diabetes mellitus, uncontrolled hyperthyroidism, phaeochromocytoma, generalised dermatological disorders, renal or hepatic impairment. Stopping smoking may alter the metabolism of certain drugs. Keep out of reach and sight of children and dispose of with care. **Pregnancy and lactation:** Only after consulting a healthcare professional. **Side effects:** Erythema, itching, urticaria, headache, nausea, vomiting, GI discomfort, dizziness, palpitations, reversible atrial fibrillation. **RRP (ex VAT):** 15mg packs of 7: £9.07. 10mg packs of 7: £9.07 5mg packs of 7: £9.07. **Legal category:** GSL. **PL holder:** Pharmacia Limited, Ramsgate Road, Sandwich, Kent. CT13 9NJ **PL numbers:** 0032/0292, 0293, 0294. **Date of preparation:** November 2005. **References:** 1. Tonnesen P. et al. A double blind trial of a 16 hour transdermal nicotine patch in smoking cessation. N Engl J Med, 1991;325:311-315. 2. Sachs DPL. et al. Effectiveness of a 16 hour transdermal nicotine patch in a medical practice setting, without intensive group counseling. Arch Intern Med 1993;153:1881-1890. 3. Russell MA. et al. Targeting heavy smokers in general practice: randomised controlled trial of transdermal nicotine patches. Br Med J, 1993;306:1308-1312.
Date of Preparation: January 2006. 00969

Adverse event reporting can be found at www.yellowcard.gov.uk

Adverse events should also be reported to Pfizer Consumer Healthcare. Tel: 01304 616161

Nicorette 16-hour patch.

Pfizer

No more than necessary.

A 15mg patch specifically designed to deliver only 16-hours of nicotine for effective smoking cessation[1]

- Mimics patients' smoking patterns to avoid nocturnal nicotine
- Does not add to the sleep disturbance associated with nicotine withdrawal[2,3]

Prescribing information can be found on adjacent page.

nicorette®
nicotine

A smart choice. A serious chance.

www.nicorette.co.uk

In brief

Co-op purchases

The Co-op Group has bought six pharmacies in North East England and South Wales. Three of the pharmacies, in Wallsend, North Shields and Ashington, have been bought from Park Chemists, and two from Wales-based W Ben Evans. A second Wallsend pharmacy was bought from Christine Clinton.

PSNC elections

Five regions are being contested in the PSNC regional representative elections. They are Trent (Ketan Patel and Gary Myers) North West Thames (Muhamad Hanif Seedat, Elizabeth Hopkins, Mahesh Shah, Robert Curd), South East Thames (Dilip Joshi, Ashwin Tanna, Sunil Chopra), West Midlands (Gamdur Singh Amaar, Rakesh Panesar, Raj Morjaria) and North Western (Mark Collins, David Ralph Bethell). Contractors have until February 28 to vote.

Genetic research

Scotland is investing £4.4 million to research how genetic and lifestyle factors cause heart disease, osteoporosis and mental illness. The aim is to identify population groups at high risk of developing inherited conditions and allow early treatment.

Dismay at response

MP Peter Kilfoyle has expressed dismay at the Government's response to the problem of fake prescription drugs. He said the issue of fake drugs entering the NHS supply chain had been raised in his constituency.

However, when questioned about the issue, health minister Jane Kennedy merely repeated the Government's strategy towards monitoring counterfeit medicines.

"I plan to rephrase the questions and put them to Parliament again," Mr Kilfoyle told *C&D*.

Questiontime

This week's question:
What is the most significant factor in despensing errors?

- Medicine pack design
- Drug name
- Prescription volume
- Working hours
- Dispensary design
- Staffing levels

You have until noon on February 14 to vote at *www.dotpharmacy.com*. We will publish the results in *C&D* on February 18.

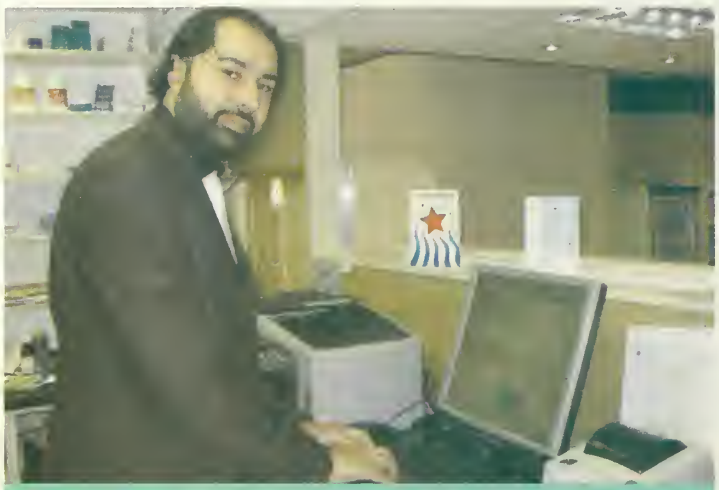
PRACTICE

100-hour independent pharmacy opens in Derby

Rosehill Pharmacy, in Normanton, Derby, is the first Numark member and one of the first independent pharmacies to open using the 100-hour exemption to the control of entry regulations.

The new pharmacy opened on February 3, and is staffed by four pharmacists as well as support staff.

At the request of Central Derby PCT, the pharmacy is providing methadone and needle exchange and emergency hormonal contraceptive services.



Shuiab Rehmat says his 100-hour pharmacy will cater for untapped local demand

Although pharmacist and business partner Shuiab Rehmat acknowledged that staff costs represent a strain on resources, he believes that the pharmacy's opening hours will cater for untapped local demand for late night and early morning pharmacy services.

He said: "Some people can only come in late at night or before work. The new contract allows us to concentrate on services, and in the hours that we are not dispensing we can provide them.

"A lot of people are coming back to us and saying that this is what is needed in the area. We were overwhelmed by demand on our first day."

Mr Rehmat also said that the exemption offered an opportunity to open a pharmacy more easily in an area already served by a Lloydspharmacy and other independents. **AC**

CONTRACT

Scotland publishes MAS specifications

An outline service specification for the Scottish minor ailment service is now available.

The specification includes information on the background to the MAS, aims and objectives of the service, a service description and outline, plus information on administration, remuneration and supporting good practice.

Guidance on the MAS formulary, plus an eMAS and new contract preparation checklist are also available

Scottish pay negotiator the Scottish Pharmaceutical General Council is advising that the service will start during the second quarter of 2006 and that remuneration, while not finalised, will be based on a capitation fee, banded according to the number of registered patients.

In addition, it is expected that a revised transitional remuneration arrangement will continue after existing arrangements end on March 31. These are currently being negotiated. **AC**

POLITICS

Call for clearer waste management guidelines

Any measures to improve the safety of healthcare waste should be practical for community pharmacists, pharmacy representatives have said.

In response to a Department of Health consultation, PSNC agrees that all who manage waste should have clear waste policy. It calls for PCTs, which have an obligation to make suitable arrangements for the collection of waste medicines from community pharmacies, to ensure that there is a relevant PCT-wide policy.

PSNC head of regulation Steve Lutener suggests that community pharmacists should be allowed to place all waste medicines in one receptacle to be disposed of as if hazardous. "This would remove the possibility of inappropriate disposal, whilst simplifying the procurement and handling of waste in the pharmacy."

Echoing this call, the Company Chemists' Association says any undue burden on pharmacies to identify and segregate hazardous waste could result in pharmacies refusing to accept returns.

Along with the NPA, the CCA called on the DoH to clarify sharps disposal, medicines returned by other healthcare professionals or nursing homes, and the collection of unwanted medicines. Head of operations Neil Slater said: "The regulations need to acknowledge and make appropriate allowances for this practice in the interests of patient care."

Ruth Wakeman, information development manager at the NPA, said there was a risk pharmacies would not offer such services which may lead to inappropriate disposal of medicines and sharps.

NEW Formulation

Senokot sugar

Calcium Sennosides

How could we possibly improve on the gentle, effective constipation relief of Senokot Syrup? Simple. By relieving it of sugar.

And because it's now sugar-free, you can recommend it to even more customers.

New formulation Senokot Syrup. We've taken away the sugar so you can add to your sales!

New 150ml Sugar Free Syrup

ESSENTIAL INFORMATION

Active Ingredients: Each 5ml spoonful of Senokot Syrup contains sennosides USP equivalent to 7.5mg total sennosides. **Indications:** Relief of occasional or non-persistent constipation. **Dosage Instructions:** Adults and children over 12: Two 5ml spoonfuls taken at night. Children 6-12: One 5ml spoonful taken in the morning. Children under 6: To be taken only on a doctor's advice. **Contraindications:** In common with other laxatives Senokot Syrup should not be given when undiagnosed acute or persistent abdominal pain is present. **Precautions and Warnings:** If there is no bowel movement after three days consult a doctor. If laxatives are needed every day or abdominal pain persists consult a doctor. Each 5ml of Senokot Syrup can provide up to 3.2k cal and this should be taken into account when treating diabetics. **Side-Effects:** Temporary mild griping may occur during adjustment of dosage. Hypersensitivity reactions associated with the esters of hydroxybenzoates (parabens) may occur. **Recommended Retail Price:** 150ml – £4.99. **Marketing Authorisations:** PL00063/0123. **Supply Classification:** GSL. **Holder of Marketing Authorisations:** Reckitt Benckiser Healthcare (UK) Limited, Dansom Lane, Hull HU8 7DS.

Senokot and the sword and circle symbol are trademarks.

POLICY

Script change system is flawed, committee told

by Asha Fowells

MPs investigating NHS charges have been told that the prescription prepayment certificate (PPC) system is flawed.

The lump sum needed to purchase a PPC is a "real issue" for those on low incomes, Ellen Schafheutle, a pharmacy research fellow at Manchester University, told a Commons health select committee inquiry last week.

Furthermore, medication needs were often unpredictable, making it difficult for patients to decide if getting a PPC was worthwhile and leaving them vulnerable to mounting costs.

Rob Darracott, corporate and strategic development director at the Royal Pharmaceutical Society, said a further problem was the lack of publicity for PPCs. Although all pharmacies displayed a poster, the scheme needed Department of Health backing. In addition, introducing more methods of payment such as a direct debit scheme would increase the availability of PPCs to those who found a one-off payment "a big slug of money", he said.

Rob Darracott: more methods of payment are needed for prescription charges

Among the suggestions for a change to the prescription charging system were:

- Total abolition. The £450 million NHS revenue generated by charges would be replaced by taxation. Patient education would encourage appropriate use of services.
- Making certain 'important' drugs exempt, rather than conditions.
- Introduce capped charges. Detectable via a fully integrated IT system across the NHS, patients would pay to a certain level, then receive free prescriptions.
- All patients on any drug to pay a low flat fee, though this would incur huge administrative costs.
- Taper prescription charges so they relate to patient income.

PRACTICE

Electronic transfer could cut care home errors

New medicine dispensing systems urgently need to be developed and tested for use in care homes, according to community pharmacist Peter Williams.

His comments came after the Commission for Social Care Inspection criticised care homes' management of medication for residents and training of staff.

Mr Williams, who provides services to three care homes in Lancashire and is also general manager of MTS Medication Technologies, said his company had developed an electronic system that improves the safety of medicine administration. It is currently under test in an NHS trust hospital and is close to emerging in the care home environment.

In its report, the CSCI said 8,000 care homes are failing to meet national minimum standards for handling drugs prescribed for residents by GPs, with some staff being inadequately trained and records not being properly kept.

The report is a follow-up to a 2004 study which identified "serious deficiencies" in the way care homes managed medicines.

Mr Williams said the reasons for medication errors are varied, eg diagnostic, prescribing, dispensing, administration and record errors. "What should be considered is what is happening within today's systems, how they are developing and the resources required to address the risk."

David Pruce, director of practice and quality improvement at the Royal Pharmaceutical Society, said PCTs need to look to commission local pharmacies to provide advice to care homes.

Peter Williams: many and varied reasons for medication errors in the care home environment

"This always used to be a service that was locally commissioned," he said. "However, it is regionally variable and whether this is because PCTs in some areas have overspent, I don't know, but not many are providing the service." **JE**

MEDICINES

Infant jabs revised to add pneumococcal vaccine

Pneumococcal vaccine is to be added to the UK childhood immunisation programme.

The three injections will be administered to infants at two months, four months and 13 months of age. The Department of Health says the move will cut the incidence of pneumococcal infections in young children, which can lead to serious illnesses such as meningitis, pneumonia and septicaemia.

Other revisions to the schedule announced by the DoH this week include: respacing the three meningitis C jabs to be given at three, four and 12 months of age, and introducing a Hib booster dose at 12 months. More information: *www.dh.gov.uk*

POLICY

Give patients a voice, Hewitt told

Patricia Hewitt: new money will be made available for community services

It is vital that patients' views inform practice based commissioning (PbC), the health secretary was warned last week.

Although the White Paper on health and social care emphasised how PbC would shape primary care, there was a danger that GPs would dictate what services were needed in their area, Patricia Hewitt was told at a debate on the White Paper organised by the charity King's Fund.

Ms Hewitt said new money would be made available to shift the focus of the NHS from acute care to community health services, but trusts needed to learn to spend the "enormous sums" they already received in a better way.

To ensure standards are maintained, particularly among health providers that win tenders in deprived areas, the DoH is to turn its attention to regulation. Such organisations, even if private or corporate, would become part of the NHS family and adopt the same ethos, Ms Hewitt said.

- In addition to strong primary care trusts, the Government needs primary care professionals such as pharmacists, GPs, nurses and allied health professionals to have the freedom to tailor services to patients, Lord Warner has said in DoH guidance on practice based commissioning (PbC).

Community-based professionals are "often closest to the needs of their patients and understand how best to access healthcare services," says the guidance.

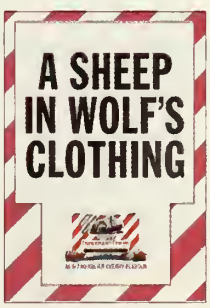
Commenting, PSNC says it has been working with Primary Care Contracting to look at how PbC will affect pharmacy, particularly the commissioning of enhanced services.

For more information:
www.tinyurl.com/75qo9

MILLIONS OF CUSTOMERS AND A CHERRY ON TOP

With a £3/4 million press and poster campaign running until March, the whole nation will definitely be getting friendly with our new flavour.

Added to advertising, we're also promoting the launch with heavy consumer sampling and a great trade promotion pack that's only available at leading cash and carries or delivered wholesalers. When you purchase 1x24 Original Extra Strong plus 1x24 Cherry flavour, we'll throw in 1x100 Cherry samples, a Perspex display unit and eight extra packets of product, for free. An offer as mouth-watering as the product.



EU plans for child meds won't work, say Lords

by Asha Fowells

European plans to use the letter P (for 'paediatric') to identify children's medicines will not work in the UK, a House of Lords report has concluded.

The letter P is used on the packaging of products suitable for pharmacy sale, and could cause confusion, the report on the proposed EU regulation of paediatric medicines warned.

But the industry-suggested alternative of using a symbol of a child on product packaging could result in people assuming the medicine was suitable for children of all ages, it claimed.

The Lords Committee responsible for the report agreed that action at a European level was needed to govern clinical trials in children and grant approval for paediatric products.

However, guidelines were needed to ensure that research encompassed children of different age groups, including neonates, to show up any age-related variations in drug response.

Proposed incentives for the pharmaceutical industry to develop more paediatric medicines solutions include extended market exclusivity.

But the report dubbed these measures "a political compromise" and "a leap of faith", saying there was no way of predicting if they would be effective or equitable. The Government should press for a full economic review of the proposals as soon as possible, it said.

Dinesh Mehta, *BNF for Children* executive editor, agreed that there were deficiencies in the planned arrangements, but said: "The vast majority of medicines that community pharmacists dispense for children are licensed and backed by an enormous body of evidence."

Beverley Hughes, MP for Stretford and Urmston, has officially opened the £3.5 million Partington Health Centre in Greater Manchester, in which there is a United Co-op Health Care pharmacy, a dental and speech and language therapy units. She is seen here talking to United Co-op operations manager Steve Coleman (right) and business development manager Jonathan Richman

MEDICINES

Tinnitus week

To mark the first Tinnitus Week, the British Tinnitus Association has sent posters to over 11,000 UK pharmacies.

The campaign posters – which will also be displayed in all GP surgeries and libraries – aims to raise awareness of the condition as well as providing contact details for the BTA. For more information, see *www.tinnitus.org.uk*, and read next week's *Pharmacy Update* which will feature a case study on tinnitus.

WHOLESALERS

Joint IT package launched

UniChem has teamed up with systems supplier Cegedim to launch a complete pharmacy IT package for its customers that will allow access to the first phase of the national electronic prescription service.

The package includes a PMR system (software and hardware), connection to the NHS IT spine and a single point of contact for IT support and user training.

UniChem IT director Anthony Roberts said: "We are offering our customers a one-stop IT solution which can be tailored to the individual needs of every pharmacy, taking away any hassle and confusion."

For further information on the offer, call 0800 0322 454.

● UniChem has launched a guide to help pharmacists prepare for enhanced services. It includes useful resources and sample-working materials such as a business plan template and guidance on preparing, choosing, setting up and evaluating a healthcare service.

RETAILING

Pharmacies 'catch up' with retailers

Pharmacies are following other retail outlets by making their stores appeal to customers.

"Pharmacies have caught up with the times in retail because they have had to," Richard Bilton, sales manager of point of sales equipment manufacturer Aures, said. "People are starting to get more savvy and are concerned about making their shops and their shop fittings look stylish.

Mr Bilton was speaking at the launch of Odyssé, a touch screen terminal with coloured fascias to fit with the colour scheme of pharmacies. The units incorporate a scanner, card scanner and cash register and require only one power outlet.

"The units look really nice on the counter and they give pharmacies a chance to really catch up with the retail boys," Mr Bilton said. The terminals are priced at around £1,800 and are available from mid-February. For more information call 01928 591 222. **CS**

MEDICINES

Charity worried by loss of animal insulins

Diabetes UK has expressed concern at Novo Nordisk's decision to withdraw its range of animal insulins in the UK by December 2007.

The decision will lead to a reduction in choice for patients, and healthcare professionals must ensure patients have a say in their treatment options, the charity said.

Novo Nordisk says it was withdrawing porcine Actrapid, Mixtard and Insulatard 10ml vials because of falling demand and the availability of newer insulin formulations and delivery devices. Demand fell by 20 per cent last year and around 12,000 UK patients will be affected.

However, Wockhardt UK has confirmed that it will continue to supply alternative products such as Hypurin Porcine in neutral, isophane and 30/70 mix versions in both 3ml cartridges and 10ml vials. Additionally, Hypurin 3ml cartridges are compatible with Owen Mumford's Autopen range (excluding Autopen 24).

WIN £25!

MUR top tips

We asked you for your top tips on conducting medicines use reviews. We will pay £25 for the best tips you send in.

David Willcocks, locum pharmacist, Llanmartin Pharmacy, Llanmartin, Newport:

Be upfront about the extent of your knowledge.

Somebody presenting with an obscure medical condition can seem quite a challenge. Most MURs tend to be opportunistic so there is little chance to swot up in advance.

The only course open is to come clean and admit your ignorance. 'Expert patients' are usually more than willing to share their knowledge and experience. This usually leads to a discussion which reveals exactly where we can be of help.

Send your top tips to *C&D* at *chemdrug@cmpinformation.com* or fax to 01732 367065 and you could win £25.

E-mail your views to chemdrug @cmpinformation.com

Fungal nail infections are not trivial

Run by patients for patients, the Skin Care Campaign represents the interests of all people with skin diseases in the UK.

We have become concerned recently to learn that several PCTs have removed treatments for fungal nail infections from their formularies, preventing GPs from prescribing them.

Skin diseases and, with them, dermatology, are not always taken sufficiently seriously, either by those members of the public not affected by them or by health professionals and health service managers. Potentially fatal conditions like skin cancer and epidermolysis bullosa aside, the quality of life issues associated with many skin diseases can be very serious.

Fungal nail infections are not trivial. Left untreated or treated inappropriately, they can cause severe complications and be damaging to patients' quality of life.

Treatments for fungal nail infections are widely used throughout the UK and we find it difficult therefore to understand why some PCTs are apparently determined to deny such treatment to their patients. Such cases seem to us to be clear examples of so-called 'postcode prescribing' – one of the least attractive residual characteristics of the old NHS.

"...some PCTs are apparently determined to deny such treatment to their patients"

We would ask pharmacist advisers to bear this in mind when reviewing formularies.

Peter Lapsley,
chief executive,
Skin Care Campaign.

ADVERTISEMENT FEATURE

Eurax Skin itch dilemmas

Number 1

Winter Worries

Itch, scratch, itch – it's not just a summer problem for your customers. Winter has its fair share of itch-inducing troubles that cause your customers both discomfort and distress – from localised dry eczema to allergic rash.

Whatever the reason for their skin irritation, they'll be seeking quick, reliable relief which will break the debilitating itch-scratch-itch cycle. And to do that most effectively you need to offer a product which has what the experts at Eurax call the sssh factor:

- S Stop the itch
- S Soothe the discomfort
- S Sustain the effect
- H Hydrate the skin

Crotamiton 10%

Why Eurax

- Only treatment to contain crotamiton - gets to work quickly and effectively to treat, soothe and moisturise
- Up to 10 hours relief
- Tried and trusted – No 1 in the anti-itch market. *IRI HBA All Outlets 52 w/e 26 November 2005.*
- Pleasant to use and easily absorbed

Eurax can relieve a wide range of winter skin irritations:
Dry eczema; dermatitis; allergic rashes; personal itching; Chickenpox

Legal category: GSL.
For more information contact the PL holder: Novartis Consumer Health, Horsham, RH12 5AB

NEXT TOPIC: DRY ECZEMA

Comment from the Editor

Oxygen: what about duty of care?

If the potential consequences weren't so appalling, the chaos following oxygen suppliers' insistence on taking over supplies would be risible. There are now serious concerns that patients suffering from respiratory problems are unable to get the relief they need, are overloading A&E and are possibly even dying.

GPs are in the frame for overloading the system by leaving it too late to transfer oxygen patients to the oxygen suppliers' 'care' (and the word is used loosely). But as bureaucracy and PCT restructuring take up so much time and energy, the mood is pity not blame.

No, the real reason for this mess is the way that big business has muscled in to demand a slice of the healthcare cake and the way that the Department of Health thought it would all make sense.

As ever, Whitehall officials have failed to consider all the unpaid and unrecognised work that community pharmacy puts in. How naïve was it to assume that the oxygen service, as run through community pharmacies, would translate easily to regional suppliers?

It is a preoccupation of this Government to encourage significant 'third party' investment in essential services from health to education to public transport. This may be fine, but when these third party providers then fail to deliver, the country seems to be so beholden to the companies' initial largesse that the Government dare not take to task those who default on their pledges.

At a time when this Government is going through the wars with its own back benchers, it really doesn't need another minor health crisis. But if those MPs had your former oxygen patients' problems brought to their attention, there just might be one.

"Big business has muscled in to demand a slice of the cake"

Our question on pharmacy this week was:
What do you think about the latest health White Paper?

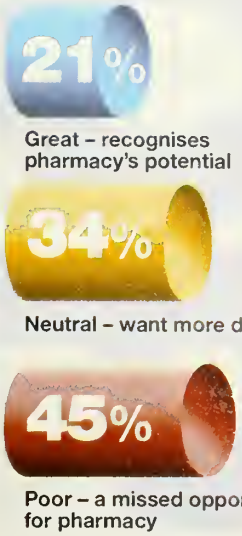
"I think it's a good idea. We should get more involved and get more directions"

Christine Kershaw, Bolton

"There is too much focus on patient choice. People want to see their GPs on the weekend but they won't be open. More emphasis should be placed on pharmacy services"

Dennis Dorrington, Isle of Wight

Our online poll at *www.dotpharmacy.com* said...



Yourviews

E-mail your views to chemdrug @ cmpinformation.com

Internet pharmacies pose a risk, says Mark Griffiths

What price progress?

When we raised our concern about internet pharmacy, it was based on feedback from Cambrian Alliance members who are all independent. Now another group of pharmacists is saying that it represents a major worry. It is ironic that they are customers of Alliance UniChem which recently applied to set up an internet pharmacy (*C&D, October 22, 2005, p6*).

Debates like those in your magazine provide a valuable service in highlighting different points of view. Change is part and parcel of the modern world and progress should be encouraged where positive. However, it is equally important that the overall impact must be assessed to ensure that gain for some does not outweigh the loss for others.

Mark Griffiths: would like to see internet pharmacies monitored

I refer to patients who may no longer have access to a full range of services from their local pharmacies as they become financially unviable. I doubt whether all pharmacy services can be supplied on the back of a supermarket delivery van. Indeed it would be interesting to know if anyone has calculated how many pharmacies would be threatened if only 10 per cent of their existing scripts were supplied in future by internet pharmacies.

Online businesses should be monitored to ensure they do not create a market weighted heavily against independents or multiples. It is interesting to note the recent concerns in Parliament over the expansion of the supermarkets and their control over the high street. Perhaps this is the 'progress' we can expect in pharmacy.

Mark Griffiths,
chairman, Cambrian Alliance.

Xrayser

TOPICAL REFLECTIONS

Top of the pops for specials leaves me cold

I am very pleased with the service I receive from my specials manufacturer, and delighted that they relieve me of all that time-consuming extemp dispensing and litigious risk, especially as I don't have to pay for the privilege. Reading last week's article on the sector (*C&D, February 4, p28*), made working in the industry sound so attractive and accessible that I wondered if I had missed my vocation.

But surely the boom times are about to come to an end for the specials manufacturers? Anyone can provide a good service when they can charge what they like for their product, but these companies' unrivalled position of setting their own prices coupled with increasing orders as pharmacists lay down their mortars could never last. The Government has cottoned on to another potential NHS cost saving, and listing the top 150 specials in the *Drug Tariff* sounds like a shrewd move on their part. I suspect, though, that like many other Government initiatives this may be rather short-sighted.

Pharmacists will shop around for the best deal on these *Tariff* products, and their prices will inevitably fall, but manufacturers will easily recoup these losses via other products outside the *Tariff*. So I can envisage all manufacturers offering these 150 products as loss leaders while the price of all other specials will rise. End result – pharmacists will have to work harder on their buying and manufacturers will have to market their 150 products aggressively, while the DoH makes no overall saving, and everyone has less time for patient care.

I can imagine all those excellent services I currently enjoy from my specials manufacturer, such as professional advice and amazing turnaround time disappear as the market is driven entirely by the price of those 150 products. Suddenly it doesn't sound like such a great place to work.

Shiny new sports car or a right-off?

Cartoon by Don Seed

They say that fortune favours the brave, and while Beran Patel was a brave man to volunteer as an initial implementer for ETP (*C&D, February 4, p32*) he seems a little down on his luck at the moment. I can see why he would want to get a head start on everyone else with ETP but he's working very hard for what might be limited benefit.

When ETP goes live Mr Patel will know the system inside out and he may even receive electronic scripts in preference to some more tardy pharmacies in the area. But at the moment he is helping AAH, NHS Connecting for Health and GPs sort out the teething problems with their systems for little apparent personal benefit.

We all know what it feels like to be frustrated by our medical colleagues, and the IT problems at Mr Patel's local surgery are typical of the type of spanner in the works that we occasionally experience. Mr Patel talks of his "shiny new sports car in the drive" that he is unable to put through its paces. There are a few of those in my drive too, labelled 'MURs', 'prescribing advice training', and 'prescription collection service', to name but a few.

I hope those Croydon GPs get their fingers out and Mr Patel is able to go for a spin, but by 2009 when he expects to see release 2 ETP his shiny new sports car will be more like a well used motor due for its MOT. If ETP is delayed by this much Mr Patel has more to lose than most, having invested early in all the necessary IT which could well be outdated by 2009.

Let's hope that the Croydon pharmacist is being pessimistic in his prediction and that he and all his less intrepid colleagues (as well as the DoH, IT system suppliers and GPs) will benefit from his hard work with a state-of-the-art ETP system to be proud of.

HOSPITAL REPORT

Launched with all guns blazing

The news the other day was full of the launch of HMS Daring on the River Clyde. This new Type 45 Daring Class destroyer looks significantly different from the type of ship I remember seeing in the past.

The number of guns on destroyers has steadily dwindled since they were first built. Instead we have the latest PAAMS - no, not any professions allied to medicine, but the principal anti-aircraft missile system. Reading the technical specification for it, I am left baffled by the jargon but it seems to boil down to an advance in technology - I assume..? It will enter service in May 2009 after all the equipment has been fitted.

I was struck by the parallel with new initiative launches in the NHS. The press and publicity machine crank up the excitement and anticipation before the launch. The initiative is launched in a blaze of publicity, with much fanfare within the service. Reading the glossy brochures can leave everyone enthused and raring to go. However, the reality is usually more prosaic and, after the initial enthusiasm has subsided, not a lot happens – at least on the surface.

"Reading the glossy brochures can leave everyone enthused..."

There is probably a lot of work happening in the background to ensure that the initiative will progress, but the majority of the service is unaware of it. When it does resurface, it has been overshadowed by the next 'big thing' and at this stage, only the strongest survive. The others gather dust on the shelf... until recycled or re-invented as the next major initiative.

Written by a senior hospital pharmacist

Blood, sweat and tears

Nearly 500 people started last year's Update Knockout, yet by October only 16 remained. **Asha Fowells** talks to the triumphant few who walked away with prizes

When you're sitting at home watching *Who Wants To Be A Millionaire?*, it's easy to think you'd get the questions right, know exactly when to gamble on a hunch, and end up accepting a £1,000,000 cheque from Chris Tarrant. But would it really happen like that?

Update Knockout is similar. First of all, you've got to be in it to win it and get all the multiple choice questions correct every month. Then you have to battle through three exams comprising more than 150 questions set by *C&D*'s external examiner. It takes discipline. It takes consistency. Most of all, it takes commitment.

Last year there was literally nothing to choose between Steve Howard, pharmacy manager at Rock Chemist in Sheffield, and Hazel Barton, a locum pharmacist who spends the majority of her time at T McLean & Sons Chemist in the Rutherglen area of Glasgow. Thanks to their amazing scores of 99.4 per cent after the three final test papers, Steve and Hazel ended up sharing the £2,000 first prize – a kind donation from Genus Pharmaceuticals.

Howard's Way

"Surprising but very exhilarating", is how Steve Howard describes his success. Since he started Update three years ago, he's always been a finalist but fallen short at the last hurdle. There were no issues this time, he explains: "I knew I was doing alright because I phoned and was told I'd got all of them right on the first test paper!"

Steve first started doing Update after he heard rumours of mandatory continuing professional development. He describes Update as "a nice thing to do. The articles are easy to read and you get instant feedback when you phone through your multiple choice answers. It's enjoyable".

The actual Knockout process, he says, is "like a treasure hunt". Steve claims he started out quite calmly, but as the year drew on and he realised he was maintaining a 100 per cent record, he admits it became more serious: "I'm very competitive – I play a lot of sport – and I thought, I want to try and win this."

But Steve adds: "You wouldn't believe the pressure." The final test papers are distributed in December, and as he says: "It comes at a very busy time of year in the pharmacy. It's hard work and I take them home, because I just don't get time at work."

Was it worth it? Definitely, says Steve, adding: "I'm very chuffed." And as for his reward, it'll go towards home improvements – he has his eye on a new kitchen and bathroom – and he says: "The money will come in very handy."


Steve Howard

Update nut

Hazel Barton is a seasoned pro when it comes to Update Knockout. In fact, her success could even be considered a return to form as she was joint winner in 2003 (compared to a positively lowly – for her – second place in 2004).

Still, Hazel clearly doesn't expect to win every year she enters the contest, describing herself as "surprised but pleased" to receive her congratulatory letter and cheque. She explains: "It's difficult to judge how well

you're doing. You just have to keep your fingers crossed and hope for the best."

Like Steve, Hazel was spurred on to do Update as part of her CPD. "It's a fairly straightforward way of getting 30 hours under your belt and covers a broad range of subjects." And she admits: "The cash incentive keeps you going throughout the year."

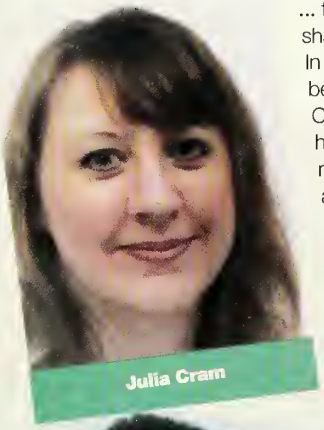
Which brings us neatly onto the money – what are her plans? A slightly rueful laugh, and she says: "Unfortunately most of it's already been spent. I've just had an expensive car bill and we went away over the new year. But I'm sure I'll treat myself with whatever little is left over."


Hazel Barton

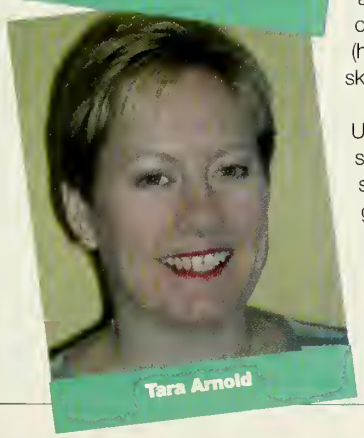
Give it a shot

It's now too late to enter this year's Knockout and compete for the £2,000 prize, but you can still register for the Update telephone marking service by calling Mary Prebble on 01732 377269. And a bit of practice this year could stand you in good stead for the future...

And not forgetting...


Julia Cram


Richard Clasen


Tara Arnold

... the three pharmacists who shared the £1,000 second prize. In the end, it was a dead heat between Julia Cram, Richard Clasen and Tara Arnold, each having got all the monthly Update multiple choice questions correct, and achieving over 98 per cent on the final test papers.

Julia Cram slots Update into her busy days managing S R Bailey Ltd on Whitechurch Road in Cardiff. She started reading Update last year as a way of doing CPD, and says the prize money was good motivation.

Her share of the £1,000 prize money will help fund her two-week holiday to Borneo, where she's planning to climb a mountain and see orang-utans.

Richard Clasen is a locum pharmacist who accesses Update articles at *www.dotpharmacy.com*. He says he was surprised and pleased to do so well at the end of his first Update year, and is planning to donate some of his winnings to the tax man (how noble) and some to his skiing fund.

Tara Arnold is a fellow online Updater who, despite coming second in 2004's contest, says she wasn't taking anything for granted this time round. Currently not working due to ill-health, she says the prize money will offset the cost of her annual retention fee, but adds: "I'll get myself a pampering treat with what's left over."

ADVERTISEMENT FEATURE

Eurax Skin itch dilemmas

Number 2

Dry Eczema

Q A customer has developed patches of itchy dry skin around his knees and elbows in the last few weeks. The skin appears flaky over the top of red inflamed areas. He is finding it irritating and uncomfortable

A This is probably dry eczema.

- Eczema is a general term used to describe various itchy skin conditions and it can be a both uncomfortable and frustrating.
- The natural reaction is to scratch but this just makes things worse. If left untreated, the skin may become more inflamed and then crack which could lead to infection.
- The application of a cream or lotion can help to break the itch-scratch-itch cycle; prevent the skin drying further and soothe the inflamed area.

Recommend Eurax cream to deliver the sssh factor

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S Soothe the discomfort
S Sustain the effect
H Hydrate the skin

Crotamiton 10%

Why Eurax

- Only treatment to contain crotamiton - gets to work quickly and effectively to treat, soothe and moisturise
- Up to 10 hours relief
- Tried and trusted – No 1 in the anti-itch market. *IRI HBA All Outlets 52 w/e 26 November 2005.*
- Pleasant to use and easily absorbed

Eurax can relieve a wide range of winter skin irritations:
Dry eczema; dermatitis; allergic rashes; personal itching; Chickenpox

Legal category: GSL.
For more information contact the PL holder: Novartis Consumer Health, Horsham, RH12 5AB

NEXT TOPIC: ITCHY DERMATIT

A FREE* supplement for your pharmacy

Now more than ever, pharmacists have the opportunity to help patients get the most from their medicines, promote healthier lifestyles and provide innovative services to the public. GlaxoSmithKline Pharmaceuticals appreciates the value of this development and has been working closely with pharmacists to produce +Plus Medicines Support Services (MSS), an initiative which we believe will support the valuable role pharmacists can play in delivering healthcare.

Every pharmacy in the UK can now benefit from these free* GlaxoSmithKline-funded services, which include:

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CPD

This article can help in the following CPD competencies: **G1a, G1d, G1f, C1d, C2e.** A list is available at *www.uptodate.org.uk/home/PlanRecord.shtml*

Managing VTE

Community pharmacists are well placed to provide anticoagulant services, say *Manisha Madhani* and *Peter MacCallum*

Venous thromboembolism (VTE) is a collective term for deep vein thrombosis (DVT) of the leg and pulmonary embolism (PE). It is a condition in which a thrombus forms, usually in the deep veins of the calf, and extends proximally. This impairs venous return, causing swelling and pain. Pulmonary embolism describes a clot that dislodges and travels to the lungs.

The annual incidence of VTE in North America and Europe is about one per 1,000 people per year; the rate increases from 0.01 per cent in young patients up to 1 per cent in those who are 60 years and over.[1] Classic risk factors for DVT include cancer, surgery and fractures and are detailed in *Figure 1* below.

Treatment options

The main treatment objectives are prevention of fatal and non-fatal PE and thrombus extension in the acute phase, recurrent VTE in the following months, and post-thrombotic syndrome.[2]

The standard treatment of VTE is anticoagulation. Treatment is started either with intravenous unfractionated heparin (UFH) or low-molecular weight heparin (LMWH). Warfarin is started at the same time because its antithrombotic effect is delayed for 72 to 96 hours.

Warfarin therapy is monitored by measuring the International Normalised Ratio (INR) and titrating the dose to achieve an INR of 2.0-3.0. Heparin is discontinued when the INR is ≥2.0 for two consecutive days, which usually occurs after five to seven days of treatment (*see Figure 2*).

Warfarin dosing and monitoring is separated into two phases. Initially a loading dose is given and the INR checked daily until the therapeutic range has been reached and sustained for two consecutive days. The INR is then checked two or three times weekly for one or two weeks, then less often, according to the stability of the results.[3]

When dose adjustments are required, frequent monitoring is resumed. Some patients on long-term warfarin therapy experience unexpected fluctuations in response due to dietary changes, concurrent medication, poor compliance, other health problems or alcohol consumption.[3]

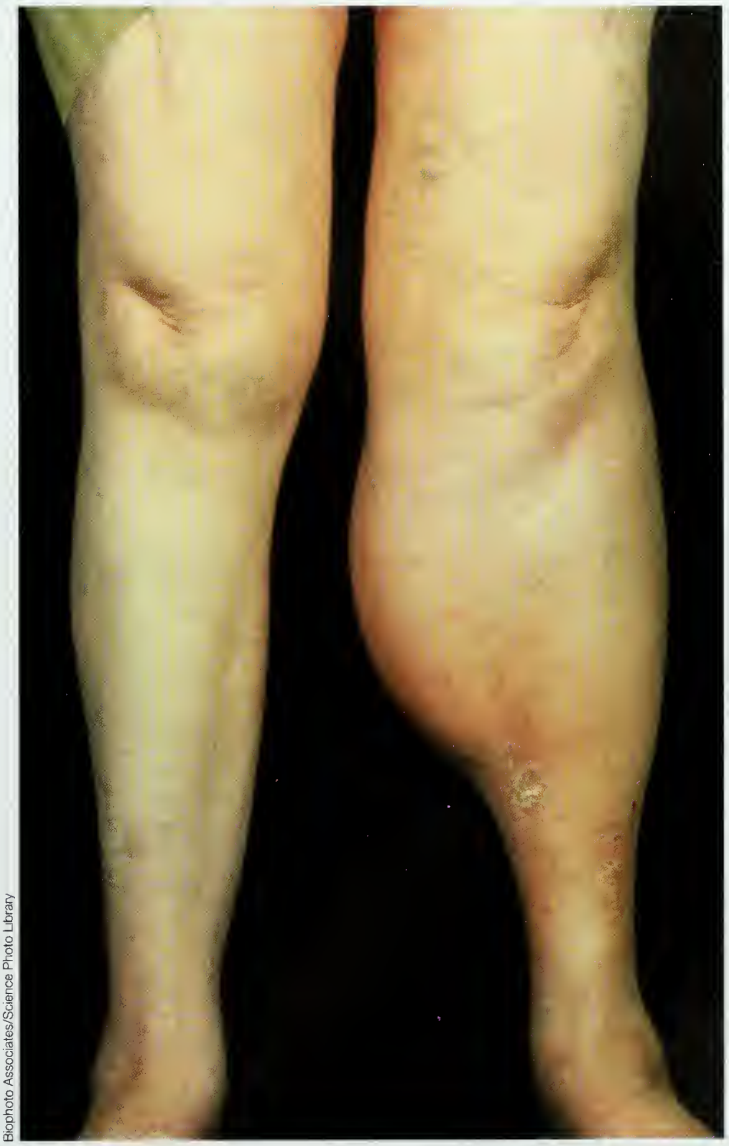
Warfarin and heparin have been the mainstay of anticoagulant therapy for the past 50 years or so. Other agents such as heparinoids and recombinant hirudin, a direct thrombin inhibitor, are occasionally used instead to manage heparin-induced thrombocytopenia. However, there is considerable interest in the development of newer anticoagulants that act at different parts of the coagulation cascade. These include direct thrombin inhibitors and factor Xa inhibitors. It is hoped that these agents will be at least as effective and have a better safety profile than existing anticoagulants and will avoid the need for laboratory monitoring.

The launch of the first of these, ximelagatran, has been held up by the regulatory authorities partly because of concerns about liver toxicity. Other agents are being intensively evaluated in clinical trials. At present, most patients

Continued on page 20

Figure 1: Risk factors for VTE

- history of VTE
- prolonged immobility
- surgery
- trauma, eg hip fractures, acute spinal surgery
- obesity
- thrombophilia
- antithrombin deficiency
- protein C & S deficiencies
- factor V leiden mutation
- prothrombin G20210 A variant
- antiphospholipid antibodies
- major medical illnesses
- hormone treatment such as combined oral contraceptives
- HRT
- pregnancy, puerperium
- cancer, especially metastatic adenocarcinomas
- prolonged travel
- age over 40 years



Biophoto Associates/Science Photo Library

A woman with a swollen left calf caused by a deep vein thrombosis (blood clot) or phlebothrombosis. DVTs are provoked by situations that encourage sluggish blood flow and increase the tendency of the blood to coagulate. The main danger is that part of the clot may become detached and cause a blockage in another part of the circulation

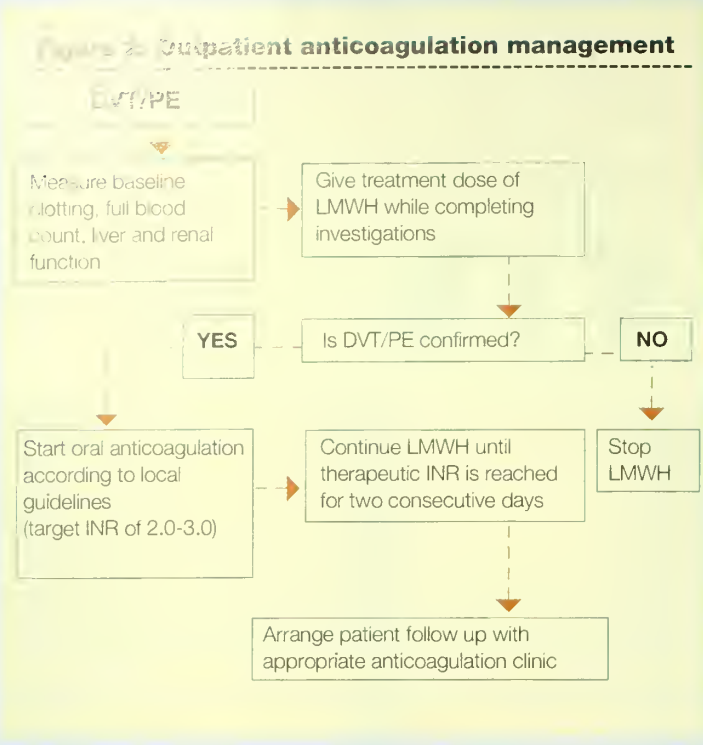


Figure 3: Mechanism of action of LMWHs

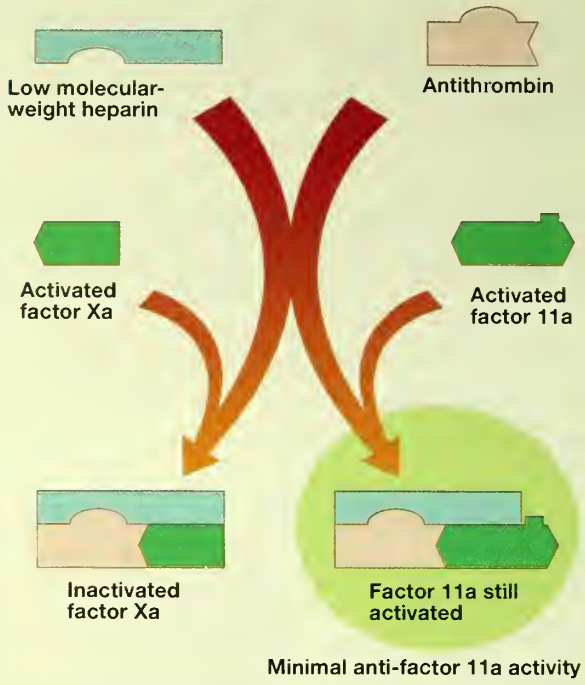


Diagram from *The American Family Physicians, February 15, 1999*

with a first episode of VTE are treated with warfarin for three to six months (*see below*). If the new agents prove successful, a greater proportion of patients might be anticoagulated long-term because of a change in the risk:benefit ratio.

Treatment duration

For most patients who have a first episode of VTE, warfarin is given for a defined period, typically three to six months. Following the cessation of warfarin, the risk of recurrence is generally 5 per cent per year, but it may be higher for those with an idiopathic event or continuing risk factors, such as antiphospholipid syndrome or cancer. Conversely it may be lower in those patients whose event occurred because of temporary, now resolved, risk factors (for example, post-operatively).

Patients with a second or subsequent episode of VTE may be treated with long-term warfarin, the optimal duration being determined by the risk of bleeding and recurrence.[1]

When anticoagulation is adjusted to achieve an INR of 2.0-3.0, the annual risk of major bleeding is about 3 per cent. The bleeding risk is associated with the achieved intensity of anticoagulation (that is, the degree of prolongation of the INR), underlying clinical disorder, age, drug interactions, history of stroke and gastrointestinal bleeding or anaemia.[3]

Unfractionated heparin (UFH)

Unfractionated heparin is a heterogenous molecule with a molecular weight ranging from 3,000 to 30,000. Only about one third of an administered dose of UFH binds to antithrombin (AT) and this is the fraction responsible for the anticoagulant effect. The heparin/AT complex inactivates thrombin (factor IIa) and factors Xa, IXa, XIa, and XIIa. Thrombin and factor Xa are most sensitive to inhibition by heparin/AT and thrombin is about 10 times more sensitive to inhibition than factor Xa.[4]

UFH has a short half-life and is given by continuous infusion. It is monitored by measuring the activated partial thromboplastin time (APTT), which tests the activity of the intrinsic and common coagulation pathways. If UFH is used for the treatment of VTE a bolus dose of 5,000 units should be given, followed by an intravenous infusion of 18units/kg/hour with doses adjusted according to the APTT. This should be measured six hours after the bolus dose and after each dose change.

The most common difficulty when starting UFH is failure to achieve a therapeutic APTT. An APTT value of 1.5 to 2.5 times the control value is commonly recommended as the target therapeutic range for UFH. Patients receiving UFH who have sub-therapeutic APTT values in the first 24 hours may have rates of recurrence 15 times higher than those with therapeutic APTT.

Traditionally patients diagnosed with DVT were hospitalised for treatment with UFH, remaining so until warfarin was administered to achieve an INR between 2.0 and 3.0.

UFH has several disadvantages: it requires hospitalisation, frequent monitoring and dose adjustments.

LMWHs

The introduction of low-molecular-weight heparins (LMWHs) has advanced antithrombotic therapy by providing effective anticoagulation without the need for monitoring or dose adjustments. It allows patients with uncomplicated DVT to be treated as outpatients, saving an average of four to five days' admission per patient.

LMWHs are derived from unfractionated heparin (UFH) by chemical or enzymatic depolymerisation. They have a mean molecular weight of 4,000-5,000. LMWHs produce their major anticoagulant effect by activating antithrombin (AT) and inhibiting the action of factor Xa.[4] They do not inhibit thrombin to the same degree as UFH (*see figure 3*).

Several clinical trials have shown that LMWHs are at least as safe and effective as UFH, and have several advantages. LMWHs have a longer half-life, a more predictable anticoagulant response and better bioavailability than UFH. These properties allow the drug to be administered subcutaneously in fixed doses without laboratory monitoring (*see figure 4*).[4]

Figure 4: Advantages of LMWHs over UFH

Pharmacokinetics characteristics	Clinical advantage
Reduced protein binding	● Good bioavailability ● Predictable dose response ● Resistance not encountered
Predictable dose response	● Fixed or weight-based dosing possible ● Monitoring not required ● Can be self-administered at home ● Saves up to five to six days admission per patient
Longer plasma half-life	● Once or twice daily dosing possible
Smaller molecule	● Improved subcutaneous absorption
Less effect on platelets and endothelium	● Reduced incidence of heparin-induced thrombocytopenia, possibly bleeding

Figure 5: Inpatient clinical trials comparing a LMWH to UFH in VTE

Study/treatment regimen	Number of patients	Episodes of recurrent VTE (per cent)	Episodes of major bleeding (per cent)
Merli *et al* (enoxaparin once or twice daily compared with UFH for VTE)[5]			
● Enoxaparin 1.5mg/kg daily	298	13 (4.4)	5 (1.7)
● Enoxaparin 1mg/kg twice daily	312	9 (2.9)	4 (1.3)
● UFH (APPT adjusted)	290	12 (4.1)	6 (2.1)
Columbus Investigators (LMWH in the treatment of VTE)[6]			
● Reviparin 35-45kg, 3,500U twice daily 45-60kg, 4,200U twice daily >60kg, 6,300U twice daily	510	27 (5.3)	16 (3.1)
● UFH (APPT adjusted)	511	25(4.9)	12 (2.3)
Hull *et al* (LMWH compared with UFH in the treatment of proximal vein thrombosis)[6]			
● Tinzaparin 175U/kg subcutaneously daily	213	6 (2.8)	11 (5.0)
● UFH (APPT adjusted)	219	15(6.9)	1 (0.5)
Simonneou *et al*[6] (LMWH compared with UFH for PE)			
● Tinzaparin 175U/kg subcutaneously daily	304	5 (1.6)	6 (2.0)
● UFH (APPT adjusted)	308	6 (1.9)	8 (2.6)
Lindmarker *et al*[6] (once daily subcutaneous Fragmin compared to UFH in the treatment of DVT)			
● Dalteparin 200U/kg daily	101	5 (5)	0(0)
● UFH (APPT adjusted)	103	3 (2.9)	0(0)
Hull *et al*[7] (LMWH compared to UFH for PE)			
● Tinzaparin 175U/kg daily	103	0	2 (1.9)
● UFH (appt adjusted)	97	7 (6.8)	1 (1.0)

Figure 6: Efficacy and safety of two trials using outpatient LMWH for proximal DVT

Study	Treatment	n	Recurrent thrombosis n (per cent)	Major bleeding n (per cent)
Levine et al	UFH	253	17 (6.7)	3 (2)
	LMWH (Enoxaparin 1mg/kg twice daily)	247	12 (4.9)	5 (0.5)
Koopman et al	UFH	198	17 (8.5)	4 (1.2)
	LMWH(nadroparin)	202	14 (6.9)	1 (2)

Efficacy and safety

Several large inpatient clinical trials have established the efficacy and safety of LMWHs for the treatment of DVT and PE. Each study demonstrated that the LMWH was equivalent to UFH for the treatment of patients with DVT with or without PE (*see figure 5*).

Two landmark studies have established the safety and efficacy of LMWH for the outpatient treatment of DVT (*see figure 6*).[6]

LMWHs licensed for the treatment of VTE in UK are shown in *figure 7*. Each agent is prepared by a different method of depolymerisation, resulting in distinct molecular weight and relative effects on factor Xa and thrombin. For this reason LMWHs are unique and not necessarily interchangeable. Although their pharmacological and clinical characteristics are similar, there are inter-class variations.

Drug selection is often based on cost, as the LMWH class is perceived as a "commodity" product. Pharmacists should base their choice on ease and frequency of administration, safety and efficacy and not on any cost/volume discounts offered by manufacturers. Whether there are any differences in the effectiveness and safety of different LMWH preparations and whether once-a-day therapy with LMWHs is as effective as twice a day remains an open question, which can only be answered by directly comparing LMWHs.

Continued on page 22 ▶

Figure 7: LMWHs available in the UK

Agent	Treatment dose for VTE
Tinzaparin	175U/kg daily
Enoxaparin	1mg/kg twice daily or 1.5mg/kg daily
Dalteparin	<46kg : 7,500U daily 46-56kg : 10,000U daily 57-68kg : 12,500U daily 69-82kg : 15,000U daily ≥83kg : 18,000U daily

Outpatient management

In the UK the treatment of DVT in the outpatient setting is now well established, with some initial studies investigating the feasibility of outpatient PE management. A recent Canadian study showed that outpatient management was feasible and safe for most patients.[8] An audit is being carried out in the UK to assess the practical implications of an outpatient treatment algorithm for PE patients prescribed tinzaparin. Initial results are expected towards the end of 2006.

Anticoagulant services

An estimated 950,000 patients are on anticoagulant therapy in the UK, atrial fibrillation being the main single indication. The increased demand for anticoagulant monitoring has placed a considerable burden on hospital outpatient clinics. Clinics in secondary care tend to be congested, with long waiting times, inconvenience to patients in terms of long journeys and with a huge finance and resource implication to the hospital transport system. With the introduction of point of care testing and computerised decision support systems, primary care is now a feasible alternative to secondary care.[9]

A variety of models are being used in primary care, such as:

- community pharmacist-run clinics.
- general practice (GP) or practice nurse schemes.
- patient self-testing, management by secondary care.
- domiciliary anticoagulation services.

There is an opportunity for community pharmacists to expand their roles in providing community based anticoagulation services. Their knowledge of drug interactions, pharmacokinetic principles and counselling skills in drug therapy makes them well suited to the role of anticoagulant practitioners. Community-based clinics offer patients the flexibility of reduced travelling and waiting time in hospitals, and associated lower costs.

Under the new general medical services (GMS) and community pharmacy contracts, anticoagulant monitoring is one of the national enhanced service initiatives for primary care. To develop the anticoagulant service in the community, providers need to establish a close liaison with the local primary care trust, which will lay down the service specification according to local demand. This will include locally agreed protocols on sampling, testing and dosing. Clinical support and advice from the local haematology department and liaison with secondary care anticoagulation clinics is vital for the safe and appropriate transfer of patients from secondary care into primary care.[10]

Training should be divided into theoretical and practical aspects. The practical training competencies would include the correct use of point of care testing and computerised decision support systems, clinic management and organisation of protocols. Clinical knowledge can be updated and initial experience gained by sitting in on an existing hospital or primary care clinic. National accreditation courses are available.

Quality standards for community-based anticoagulation services are essential in order to manage and minimise risks and to provide a framework for the quality of care and performance of the service.[11]

With suitable training and support, community pharmacists are in an ideal position to take over the monitoring of oral anticoagulants, with considerable benefits to patients in terms of safety and convenience.

Manisha Madhani is an anticoagulation pharmacist and Peter MacCallum a consultant haematologist at the Barts and the London NHS Trust.

References available on request.

Hand-held INR monitors have aided the development of community pharmacy anticoagulation services

Medicalmatters

Flexible approach to methadone dosing urged

Health professionals should adopt a flexible approach to methadone dosing rather than rigidly sticking to recommendations.

A US study looked at 222 patients who had a history of substance misuse and were started on methadone therapy. Methadone maintenance doses in the 168 patients who achieved opioid abstinence for more than one month ranged from 1.5mg to 191.2mg. By comparison, in the 25 per cent of patients who did not achieve abstinence, the methadone dosage ranged from 20mg to 150mg.

The authors conclude: "These data suggest that clinicians should be allowed significant flexibility in methadone dosing as long as outcomes are positive. Minimum dosage requirements are not necessary; however, clinicians must recognise that a subset of patients will be underdosed at doses as high as 140mg/day."

Drug screening should be used to determine appropriate effective doses, suggest the researchers, adding that higher doses are likely to be necessary in individuals with post-traumatic stress disorder, depression, prior withdrawal attempts and those who use low-purity heroin.

For more information:

www.plosmedicine.org

Care needed when using SSRIs in pregnancy

Babies born to mothers who took antidepressants during pregnancy are likely to develop withdrawal symptoms, say clinicians in Israel.

In apparent contradiction to a recent paper that advocated SSRI use in pregnant women (*C&D, February 4, p22*), the authors say that around one third of newborn babies in their study exhibited neonatal abstinence syndrome.

The researchers compared 60 babies exposed to SSRIs for a prolonged period of time to 60 control infants. None of the control subjects showed any symptoms of withdrawal, which include high-pitched crying, tremors and disturbed sleep.

The authors call for careful risk:benefit assessment of continuing SSRI treatment in pregnancy, and suggest using the minimum effective dosage and avoiding polypharmacy as "prudent". In addition, SSRI-exposed infants should be observed for a minimum of 48 hours and followed up to assess the long-term effects, they say.

For more information:

Arch Pediatr Adolesc Med 2006; 160: 173-176

Self-testing warfarin is best

Patients who self-manage their oral anticoagulation therapy have better outcomes than those who don't, says a paper in the *Lancet*.

Oxford researchers analysed 14 trials of anticoagulant monitoring. Patients who self-monitored their warfarin levels were 55 per cent less likely to have thromboembolic events, 35 per cent less likely to suffer a major haemorrhage, and had a 39 per cent relative reduction in all-cause mortality compared to those who did not self-monitor. Furthermore, those who adjusted their doses in response to INR levels experienced lower mortality and fewer thromboembolic events.

However, self-monitoring is not feasible for all patients: limitations include expensive testing strips, the reliability of devices, the reluctance of individuals to participate and training required, conclude the authors.

No link between Pill and weight

There is no evidence that combined contraceptives cause weight gain, a Cochrane review has concluded.

Data from 44 trials that considered the issue was not sufficient to determine whether the contraceptive Pill or patch affects weight, say the researchers. However, they add that most comparisons of different contraceptives showed no substantial weight changes, and that few women discontinued their medication for this reason.

Due to the limited amount of data available (only three placebo-controlled, randomised trials were considered suitable for analysis), the review advised that more research is needed. In particular, future work should look to control other factors that influence weight gain over time, it suggested.

For more information:
www.thecochranelibrary.com

CoaguChek XS

Roche Diagnostics has extended its coagulation monitor offering with the introduction of the CoaguChek XS device.

A follow-up to the existing CoaguChek S, the new monitor includes a quality control system to ensure results are correct when displayed, and is light and compact. The machine uses NHS-prescribable CoaguCheck XS test strips, which do not require refrigeration and are said to be easier for patients to use.

The cost to patients is £399.00. As a VAT-exempt purchase, pharmacists are required to complete a form that is included in the pack when selling a monitor. Although there is no facility for patients to trade in a CoaguChek S meter, Roche is offering an interest-free payment plan.

A CoaguChek XS meter for use by health professionals, and an accompanying larger pack size of test strips will be launched later in the year, said a Roche spokesman.

Price: £399.00 ex VAT
Pip code: 319-5724
Roche Diagnostics Ltd
Tel: 01273 484567

End of Paediasure

Abbott has announced plans to withdraw Paediasure Fibre 250ml cans from the UK market in May.

Continued supply of this presentation is no longer viable, explained the manufacturer, adding that the product would remain available in 500ml ready-to-hang packs and 200ml cartons.

For more information:
Abbott Laboratories Ltd
Tel: 01795 580099

Xyrem liquid

Xyrem oral solution (sodium oxybate 500mg per ml) has been launched by UCB Pharma.

The product is licensed for the treatment of cataplexy in adult patients with narcolepsy, and should be initiated and monitored by a sleep disorders expert. The recommended starting dose is one 4.5ml dose at bedtime followed by a second 4.5ml two and a half to four hours later. Each dose must be diluted with 60ml of water prior to ingestion.

Price: £360.00
Pack size: 180ml
Pip code: 074-5471
UCB Pharma Ltd
Tel: 01753 534655

Risperdal Consta

A new reconstitution system will replace the three needle-giving set for Risperdal Consta (risperidone) from March 1.

The Smartsite needle-free vial access device has been designed to reduce the risk of needle stick injury and the time taken for reconstitution. Demonstration packs and training are available from Janssen-Cilag by telephoning 0800 731 8450.

Sinequan to go

Due to manufacturing reasons, Pfizer is phasing out the Sinequan range (doxepin) this year.

Currently, the company expects to stop supplying the 50mg capsules in June, 75mg and 25mg strengths in October, and the 10mg presentation in November. No generic formulations of doxepin are available in the UK.

For more information:
Pfizer medical information
Tel: 01304 616161

Ludiomil

Ludiomil 75mg tablets (maprotiline hydrochloride) will be discontinued on March 1, Novartis has announced. Ludiomil 25mg tablets will remain available.

For more information:
Novartis Pharmaceuticals UK Ltd
Tel: 01276 692255

ADVERTISEMENT FEATURE

Eurax Skin itch dilemmas

Number 3

Itchy Dermatitis

Q A customer has come in with a very itchy rash all over her upper body after wearing a borrowed sweater. She has very sensitive skin and normally only washes her clothes in non-biological powder.

A This is probably itchy contact dermatitis.
- This usually only affects adults and occurs when the skin reacts to contact with a trigger e.g. , an allergy-provoking chemical or, substance - such as washing powder, perfume or soap
- Only the area which comes into contact with the trigger is affected

Recommend Eurax cream to deliver the sssh factor

S Stop the itch
S Soothe the discomfort
S Sustain the effect
H Hydrate the skin

Crotamiton 10%

Why Eurax
- Only treatment to contain crotamiton - gets to work quickly and effectively to treat, soothe and moisturise
- Up to 10 hours relief
- Tried and trusted – No 1 in the anti-itch market. *IRI HBA All Outlets 52 w/e 26 November 2005.*
- Pleasant to use and easily absorbed

Eurax can relieve a wide range of winter skin irritations:
Dry eczema; dermatitis; allergic rashes; personal itching; Chickenpox

Legal category: GSL.
For more information contact the PL holder: Novartis Consumer Health, Horsham, RH12 5AB

Flower power for feet

Carnation Footcare is being revamped in a £500,000 initiative aiming to modernise the 85-year-old brand. The carnation icon is being retained but freshened up to attract the next generation of customers, says Carnation.

The new look is being launched in March and will unify the footcare range. In support, national PR activity begins this month to be followed by print advertising, online activity, sampling, in-store promotions and brand partnerships.

For more information:
Cuxson Gerrard
Tel: 0800 018 7117
www.carnationfootcare.co.uk

Early pollen puts Zirtek on alert

Zirtek is aiming to maintain its dominance in pharmacy with a range of promotional activities this year, says manufacturer UCB Pharma.

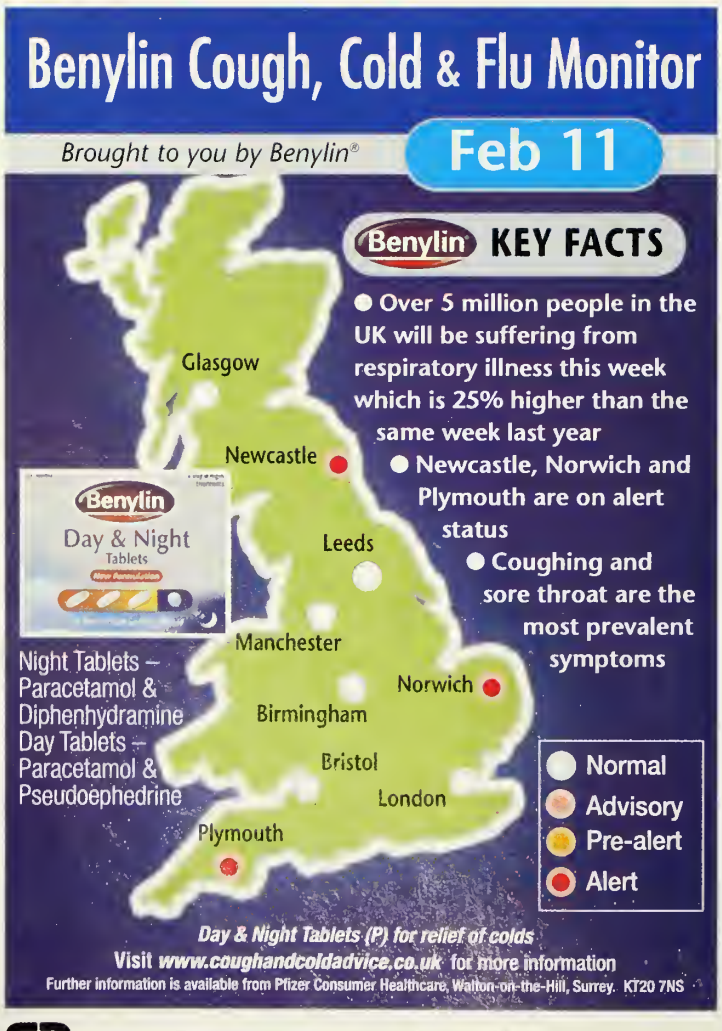
A "high visibility multimedia advertising campaign" is planned, expected to reach over 50 million consumers. Exact details are yet to be finalised but activity is running throughout the year with the primary focus on the run up to the main hay fever season. For stockists wanting to boost brand awareness, point of sale materials including hanging posters, pop-up window displays and shelf talkers are available (tel: 01202 780 558).

According to IRI retail sales data for 2005, Zirtek is the leading single active tablet brand in the sector. Tablets are the format of choice, with 64 per cent of hay fever doses sold in this presentation, a trend IRI expects to continue for the foreseeable future.

● Hay fever sufferers can expect an early start to the season this year. Birch pollen reaches highest levels every other year and 2006 is due to be a heavy year.

Furthermore, the cold winter could see birch trees release their pollen up to two weeks earlier than some years. Professor Jean Emberlin of the National Pollen and Aerobiology research unit is predicting birch pollen to arrive in late March, with very high counts in many areas. But hay fever sufferers caught off-guard may put their symptoms down to a cold, believes Zirtek.

For more information:
UCB Pharma
Tel: 0800 953 0183
www.zirtek.co.uk



Arheumacare has joint approach

Arheumacare, a capsule plus tablet combination product for joints, has been launched by Health Perception.

Each tablet contains 665mg glucosamine (providing 500mg glucosamine sulphate on absorption), 165mg turmeric and 40mg ginger extract while capsules contain 400mg each of cod liver oil and borage oil and 200mg omega 3. A tablet and capsule taken once daily tackle joint problems including inflammation, stiffness, pain and reduction in joint function, and tiredness and weakness resulting from an immune system suffering from low natural resistance, claims Health Perception.

A £1 million national advertising campaign is being planned for late spring.

Price: £12.99
Pack size: 30 tablets and 30 capsules
Pip code: 229-2621
Health Perception
Tel: 01252 861454

Family Doctor tackles anxiety

Understanding Anxiety and Panic Attacks is the title of the latest addition to the Family Doctor series of books.

The book explains the symptoms of the conditions and covers the treatment options, both medical and psychological, available. Author and consultant psychiatrist Dr Kwame McKenzie lectures in psychiatry at University College London.

Price: £4.75
Pip code: 229-2225
Family Doctor Publications
Tel: 01202 668330
www.familydoctor.co.uk
E-mail: *familydoctor@btinternet.com*

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SSL focuses on its favoured four

SSL's promotional activities for its OTC portfolio will this year focus on four brands: Medised, Meltus, Paramol and Full Marks.

Paramol will be appearing on television in a 'heavyweight' campaign with a double burst of activity planned for spring and later in the year. The brand is experiencing 17 per cent MAT growth, says SSL, and is the fastest growing analgesic brand. Following last October's TV campaign, sales grew by 78 per cent, reports SSL.

For the Full Marks head lice brand, plans are afoot to maintain product awareness throughout the year, with activity scheduled for the spring, summer and autumn school terms. Last year's successful TV advertising will be repeated during August and September in a bid to maintain the brand's market value share of 73 per cent. A website, *www.headlice.co.uk*, supports the brand.

Medised, the second fastest growing brand in the market, has seen an increase in sales since its TV debut late last year. Traditionally a winter product, out of season sales of Medised are up since the brand's repositioning into pain and fever relief last summer. Further TV exposure is planned for this year.

Meltus, the fastest growing cough brand with year on year sales up 11.9 per cent against a cough market growing at 4.1 per cent MAT (*source: IRI total market 52 w/e 24 Dec 05*), will continue to be promoted during the winter months, with the Max Meltus character taking centre stage.

For more information:
SSL International
Tel: 0870 122 2690

Clearasil

Crookes says Clearasil's re-launch will signify two new launches: Daily Oil Control with green tea and peppermint, and Daily Blackhead Control with natural sea salt.

Patchwork pain relief

Period pain heat patches have been launched by Nurofen.

Said to provide eight hours of relief from period pain, the patches feature an adhesive area allowing attachment to clothing and are shaped to fit the abdomen or back.

The patches work by increasing blood flow and relaxing cramping muscles. When a sachet is opened, air activates the patch which warms up gradually.

An estimated 3.3 million women suffer with period pain. Of these, 67 per cent experience symptoms every month and 21 per cent every two to three months.

Price: £3.99
Pack size: two
Pip code: 320-6919
Crookes Healthcare
Tel: 0115 953 9922
www.nurofen.co.uk

Nivea raises the SPF ante

Nivea Sun is upping the SPF in its sun protection range.

Baby sun lotion SPF50+ is the first Nivea sun product designed specifically for babies. The alcohol, colorant and perfume-free formulation has been clinically tested and is very water resistant, says manufacturer Beiersdorf.

For older children, additions to the range include SPF30 and SPF50+ sprays, and SPF25 and 50+ lotions.

New for adults are Sun moisturising sun lotion SPF30 and SPF50+, and an SPF50+ spray. All products in the adults range contain the skin hydrator hydramine.

On the self-tan front, Sun touch quick and easy self-tan wipes are now available. Single sachets can cover the face and arms or legs and contain macadamia nut oil. Finally, Self tan quick and easy aerosol spray is now available in a fair skin variant.

Price: £1.29 (self tan wipes) to £15.99 (Children's sun spray SPF50+)
Pip codes: *see C&D Pricelist*
Beiersdorf
Tel: 0121 329 8800
www.nivea.co.uk

Genus moves on five brands

Genus Pharmaceuticals has acquired five brands from Sankyo Pharma: Movelat, Cetraben, Hirudoid, Anacal and Dermacort.

The move follows Sankyo's global strategy to focus on cardiovascular and diabetes care.

For more information:
Genus Pharmaceuticals
Tel: 01635 568400

TV next week

Anadin Extra: All areas

Bassett's Soft & Chewy Omega 3 Vitamins: GMTV, Sat

Blistex: GMTV, Sat

Buscopan IBS Relief: C4, GMTV, Sat

Buttercup Cough Syrup: C4, GMTV, Sat

Calprofen: All areas except GMTV

Canesten Duo: All areas

Clearblue: ITV

Cura-Heat Arthritis Pain: All areas except GMTV, Sat

Cura-Heat Back Pain: All areas except GMTV, Sat

First Response: All areas except five

Haliborange Omega-3 for Kids range : C4, GMTV, Sat

Kool 'n' Soothe Kids: All areas except C4, five

Kool 'n' Soothe Migraine: All areas except C4, five

Multibionata Activate: C4

Olbas range: five, GMTV, Sat

Palmer's Cocoa Butter formula: C4, Sat

Pearl Drops: All areas except five

Rennie: All areas except CAR

Seven Seas Cod Liver Oil: All areas except C4

Seven Seas Joint Care: All areas except C4

Soothagel: five, GMTV

PharmaSite for next week: Zovirax – Windows, **Thornton & Ross – Fluconazole** – In-store **Thermacare** – Dispensary

Pharmacy channel: Buscopan, Eating Disorders Association

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

NEW

Fortisip Protein and Fortimel now in easy to use bottles

Fortisip Protein and Fortimel are now available in 200 ml easy to use plastic bottles. The bottles are significantly easier for patients to handle than cartons[1] and can reduce spillage and waste. The product itself is unchanged but there are new order codes.

New Fortisip Protein Bottle and Fortimel Bottle - Ordering Information

UK Code	Product Description		PIP Code
18332	Fortisip Protein	Vanilla 200 ml	319-9940
18335	Fortisip Protein	Strawberry 200 ml	319-9957
18340	Fortisip Protein	Forest Fruit 200 ml	319-9965
18345	Fortisip Protein	Chocolate 200 ml	319-9973
18358	Fortimel	Vanilla 200 ml	319-9981
18367	Fortimel	Strawberry 200 ml	319-9999
18384	Fortimel	Forest Fruit 200 ml	320-0003
18402	Fortimel	Chocolate 200 ml	320-0011

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Reference: 1. Data on File, Nutricia Clinical Care, February 2005.

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AS 1230

UK preparations for the potential flu pandemic continue, with pharmacists having a key role to play, says Kathryn Godfrey

One flu over the cuckoo's nest

Media headlines about the risks posed by bird flu have raised public anxiety and, in many cases, have obscured the key facts.

A form of avian influenza, the H5N1 strain, commonly known as bird flu, has been infecting birds in parts of Asia since 2003. As a result of close and direct contact with infected birds, 148 people have also caught the infection. Of these, just over half have died. The five countries in Asia where humans have been affected are Thailand, Vietnam, Cambodia, Indonesia and China.

At the turn of the new year, cases of bird flu and human fatalities occurred for the first time in Europe. In January, the first cases were reported in Eastern Turkey with the deaths of three teenagers and a possible fourth. Over 300,000 birds were culled within two weeks, a process which was hampered by the remoteness and poverty of the region. During the same month the infection spread geographically, with cases of H5N1 being found in western parts of the country. In common with the deaths in Asia, the Turkish deaths were also the result of close contact with infected birds.

In December 2005, the Advisory Committee on Microbiological Safety in Food (ACMSF) reviewed recent developments on avian flu and its implications for food-borne transmission in the UK. The ACMSF concluded that the risk of acquiring avian flu through the food chain was low, and that there was no direct evidence to support this route of infection.

Nevertheless the EU has banned imports of all poultry and its products from affected areas, so in the UK it is safe to eat such food. The usual recommendations for cooking and hygienic preparation remain.

Concern at the World Health Organization and at UK bodies, including the Health Protection Agency, is not just about the current status of the virus, but also about the future. There is evidence that the H5N1 strain has the capacity to jump the species barrier and the potential to cause severe disease with high mortality in humans.

An allied concern is that this could prompt a global influenza epidemic in humans. Scientific research shows that avian and human influenza viruses can exchange genes if a person is infected with both at the same time.

Scientists at the National Institute of Medical Research in London who analysed samples from the Turkish cases did find a genetic change in the virus. But they concluded that it did not make it more likely that it could pass between humans.

As Professor Stephen Denyer, who chairs the Royal Pharmaceutical Society's Science Committee emphasises, the current risk of contracting avian flu is "very small ... there is currently no known variant of avian flu which can be passed from human to human".

However, he adds: "The anxiety is that the circumstances will arise where someone who is harbouring the virus from birds also becomes infected with human flu. And that the combination creates a variant which carries the infective capability of the flu virus with the pathogenic consequences of the avian variant."

It is likely that the resultant strain would be significantly different from others in circulation, which means that few people will have any immunity to it. This will allow it to spread widely and easily, and to cause serious illness which could be fatal.

This is the scenario which creates a pandemic, (defined as a global epidemic occurring over a wide area, crossing international boundaries and affecting a large number of people). In the last 100 years there have been three pandemics, the most serious

How to avoid catching flu

- Cover the mouth when coughing or sneezing.
- Use a tissue when possible.
- Dispose of tissues promptly and carefully.
- Avoid non-essential travel and large crowds where possible.
- Follow good basic hygiene by washing hands frequently with soap and water to reduce the spread of the virus.
- Clean hard surfaces such as kitchen worktops and door handles frequently.
- Encourage children to follow these measures.

CPD

This article can help in the following CPD competencies: G1m, G1o, G8a, C2a. A list is available at *www.uptodate.org.uk/home/PlanRecord.shtml*

Characteristics needed for a flu virus to cause a pandemic

- Ability to infect humans.
- To cause illness in a high proportion of those infected.
- Be able to spread easily from person to person.
- Be significantly different from previous strains.

being that which occurred at the end of the First World War. This flu pandemic caused 250,000 deaths in the UK and an estimated 20 to 40 million deaths worldwide.

However, it is not possible to quantify the extent of the risk if the virus mutates. Professor Denyer points out: "We will at some stage get a combination of the avian and the flu virus. It could be that it is super-infective and it could be super-pathogenic. Or it could be relatively poorly infective or relatively poorly pathogenic. It's not a given that all the worst characteristics are going to come together in a variant. At the moment I think that our level of preparedness is correct – over-anxiety is not necessary at this stage."

Professor Denyer stresses the role pharmacists have to play in educating the public. "Pharmacists can help people realise that, while there is a chance of mutation, and therefore a risk of pandemic infection, as yet the conditions have not yet come together to make it a real threat," he points out.

Experts at WHO are predicting anything between two million and 50m deaths worldwide when the next pandemic occurs. Global co-operation is crucial to limiting the effect of any pandemic. For this reason, countries across the world are being encouraged to work together.

If the right preparations are made and the correct actions are carried out speedily, WHO believes that an influenza pandemic could be averted. A meeting of delegates from 100 countries in November 2005 organised by WHO, the Food and Agriculture Organisation, the World Organization for Animal Health and the World Bank identified key areas of action.

The first priority remains reducing the risk of infection from infected poultry. All outbreaks must be identified and acted on speedily using measures including the destruction and proper disposal of all infected or exposed poultry stock. For example, in 2003 in Holland around 30m birds out of a total population of 100m were culled within a week.

The other key areas identified were surveillance, rapid containment, preparedness, integrated country plans and effective communication. In January, the European Union pledged a further £56m to help countries deal with the threat of avian flu. A meeting in December of the European Union Health Council emphasised the need for countries to urgently complete national contingency plans.

Compared with other countries, the UK preparations and plan are relatively well formed. The difficulty is planning for the unknown. The Health Protection Agency speculates that if a pandemic develops it is likely to reach the UK in less than a month and it would take a further two to three weeks to spread across the UK. Subsequent waves are likely weeks or months later.

The UK contingency plan pivots around a scenario which expects one in four of the population to be affected, leading to over 50,000 deaths.

In October 2005 the UK health departments published an update of the *UK Influenza Pandemic Contingency Plan*. It provides the overall framework for the UK's response to an influenza pandemic and is based on current WHO advice. The response is divided into phases: an initial one, which covers the preparations to be carried out before a pandemic, or potential pandemic emerges, followed by a stepped escalating response as a pandemic evolves.

The prime objectives of the plan are to "save lives, reduce the health impact of a pandemic and minimise disruption to health and other essential services, while maintaining business continuity as far as is possible and reducing the general disruption to society".

The plan is working on an estimate that the average weekly death rate in the UK of 12,000 could double. Mortality rates will cover all the age groups with at least a third of the total excess deaths being in people under the age of 65 years, which compares with less than 5 per cent in normal times.

Antiviral neuraminidase inhibitors, which will hopefully but not definitely reduce the severity of the illness, are being stockpiled. The ultimate aim is to have 14.6m doses of oseltamivir (Tamiflu) to treat a quarter of the population. This should be achieved by the end of 2006.

A study published in January in the *New England Journal of Medicine* reported on two cases of human infection in Indonesia which suggested that the virus could be developing resistance to Tamiflu. The analysis of the Turkish cases at the National Institute of Medical Research showed that the virus was sensitive to Tamiflu and also to amantadine. Researchers at the institute suggested that if the virus does mutate to a form which can be spread between humans then a combination of drugs may be needed.

Preparatory work is being carried out to pave the way for production of a suitable vaccine, but a specific vaccine is unlikely to be available in any quantity in the early stages of a pandemic. When it does become available, stocks will be earmarked for essential groups until it is more supplies exist.

David Pruce, Royal Pharmaceutical Society director of practice and quality improvement, says that pharmacists will be at the forefront of activity if a pandemic occurs. At the height of a pandemic, he thinks pharmacists would receive a massive increase in the number of visits, to the order of 400–500 a week. There could also be difficulties in the supply of usual medicines due to travel restrictions.

Mr Pruce is urging pharmacists to be aware of developments and for local pharmaceutical committees to ensure they are fully involved in the formulation of local contingency plans. Some local plans include police protection and Mr Pruce comments: "During a pandemic there could be real panic among the public with the possibility that people will try to break into pharmacies to gain access to Tamiflu." In addition, the contingency plan considers the option of moving stocks of antiviral drugs and vaccines to central points to make it safer to distribute. The plan also suggests that health professionals such as pharmacists may be involved in giving vaccines.

"Pharmacists would receive a massive increase in the number of visits"

Once an effective vaccine has been developed it will first be given to priority groups, one of which will be "workers required to keep essential services going". The RPSGB's view is that pharmacists should be within this group and is in discussion with the DoH to confirm this position.

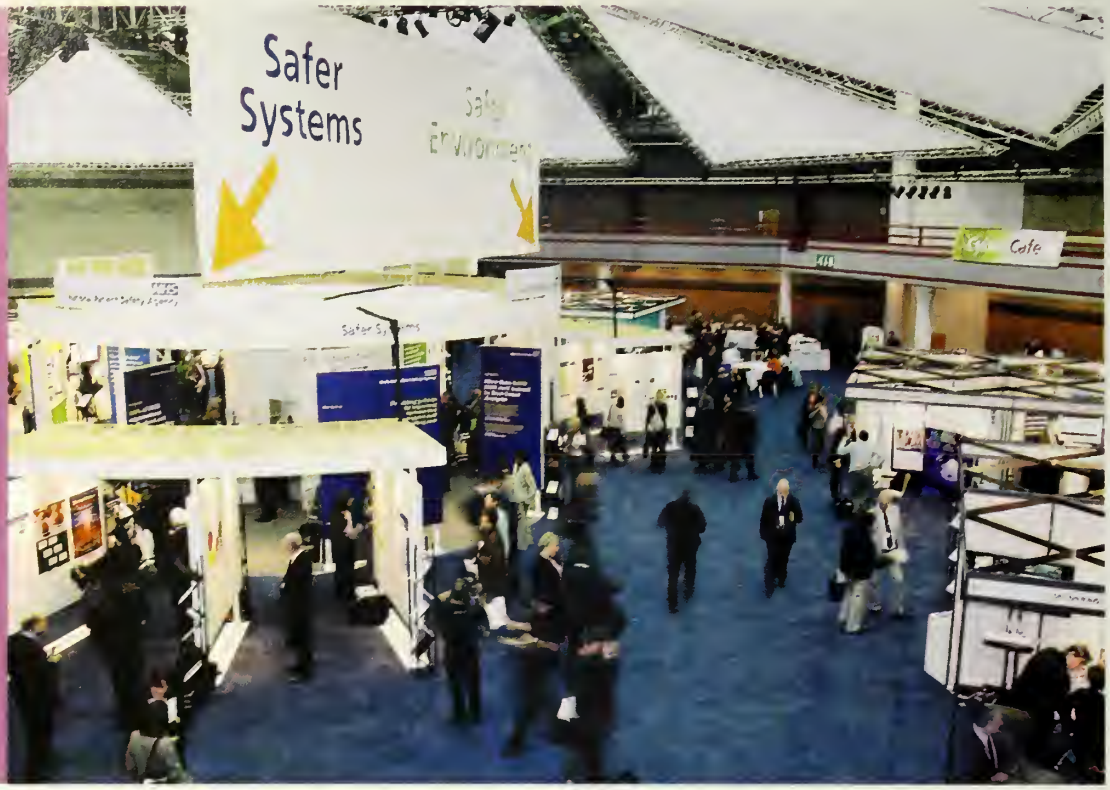
Because the actuality and the detail of a pandemic is not known, it is not possible for pharmacists to make concrete preparations. But Mr Pruce says: "Pharmacists need to be aware. They need to keep up to date of developments and of local plans. The overall message is be aware but don't panic."

This article was provided by the Royal Pharmaceutical Society of Great Britain.

Information sources

- Department of health at *www.dh.gov.uk*
- European Commission at *http://europa.eu.int/*
- Department for Environment, Food and Rural Affairs at *www.defra.gov.uk*
- World Health Organization at *www.who.int*
- Health Protection Agency at *www.hpa.org.uk*
- Food Standards Agency at *www.food.gov.uk*

To err is human, but in healthcare mistakes can be a matter of life or death. **Caroline Stocks** reports from the National Patient Safety Association's 2006 patient safety conference last week



Play it **safe**

While it is impossible to avoid mistakes, learning why they occurred and how they could be prevented in future was the key message at the conference.

The two-day event in Birmingham offered people across the NHS an opportunity to learn more about reducing the likelihood of mistakes as well as continuing to improve safety in the future.

Error reporting on the increase

Since the NPSA launched its anonymous error reporting system last year more than 500,000 errors have been logged, with over 30 per cent of these coming from primary care.

The NPSA expects the number of reports from community pharmacy to increase dramatically in the coming months with the new requirements to report incidents as part of the pharmacy contract in England and Wales, and with increasing connectivity to the NHS.

"The database is turning out to be extraordinarily valuable," Susan Williams, NPSA joint chief executive, said. "The number of reports we have so far received is a sign that a reporting culture is beginning to take shape."

Patients will also be encouraged to participate in error reporting as part of the new NHS 'Please Ask' campaign. The campaign, due to be rolled out across England and Wales next month, will encourage patients to feel comfortable asking questions and raising concerns with healthcare professionals. Patients will also be able to use the Please Ask website to share safety concerns with the NPSA.

The new systems for logging errors reveal a more systematic attitude to reporting and learning from mistakes. An increase in public, political and professional awareness in patient safety provided the impetus for this approach, health minister Jane Kennedy said.

"The majority of patients receive safe and effective care but mistakes can and will inevitably happen."

The increase in incident reporting shows health trusts are making progress in creating an environment where staff are willing to report, the minister said. "But there's still more to do. There needs to be commitment to an open and honest culture."

Ms Kennedy said there is a need to make better use of systems currently in place to share lessons learnt from reporting and assessing errors. As part of the Government's new *Redress Bill* the public will be able to expect explanations about why errors occurred and a guarantee healthcare professionals will work to make sure the mistake does not happen again.

"It's about delivering a better response and supporting the NHS to learn from the mistakes, to deliver better

"There needs to be commitment to an open and honest culture"

Jane Kennedy, health minister

care in the future," she said.

The Government will continue to examine how good practice can be extended across all healthcare professions and has said patient safety will be at the centre of all NHS developments, Ms Kennedy said.

The minister spoke of safety being at the hub of the NHS as healthcare is developed to allow greater patient choice and local service commissioning to meet local needs. "We have to achieve greater choice of healthcare provision for patients in a way that doesn't deter providers from developing an open culture in reporting errors," she said.

"The number of reports we have so far received is a sign that a reporting culture is beginning to take shape"

Susan Williams, NPSA joint chief executive

Admitting errors, avoiding blame

While the Government is keen to develop an open culture of reporting to improve patient safety, assuring staff they won't be blamed if they admit their mistakes can be difficult. Speakers were keen to point out admitting to errors should not lead to people being blamed for mistakes.

"It's not about who is to blame for something going wrong but how and why did it occur and what can be done to stop it happening again," Maureen Baker, the NPSA's special clinical advisor, said.

Pharmacies and primary care organisations were encouraged to conduct significant event audits (SEAs) to log errors and help staff learn from them.

Ms Baker suggested six steps to SEAs, from acknowledging the error to addressing how the error can be overcome.

"It's one of those things that once people start doing it they don't stop," she said. "We need to maximise learning from SEAs into finding out what's going wrong in healthcare, particularly primary care.

"SEA is an important tool for reflection and learning and we want to share learning across healthcare communities."

Ms Baker also suggested SEAs could be used when something has gone well in a pharmacy team rather than focusing on errors.

"SEAs are often restricted to when something's gone wrong, but they can also apply to when something has gone well. It's possible to learn from excellence as well as catastrophe," she said.

"The key to it all is learning to avoid mistakes and improving safety for patients."

Continued on page 32 ▶

Six steps to conducting Significant Event Audits

1. **Identify an incident**.
2. **Collect information** on the incident.
3. **Hold an SEA meeting**. Either as part of a staff or team meeting or hold a separate meeting so staff know there is a dedicated time to discuss incidents
4. **Analysis**. The person who brings the SE normally explains what happened and what they think went wrong or well. The incident needs to be discussed to establish what caused it.
5. **Recommendations and review.** Discuss how to make sure good practice occurs and decide what to do to minimise negative events happening again.
6. **Report and share.** To get maximum learning from incidents ensure learning and outcomes are shared within the team and across pharmacies.

ADVERTISEMENT FEATURE

Chan Patel MRPharmS

of Imperial Pharmacy in Tunbridge Wells, purchased the Healthpoint counselling system in April 2005. In an interview given in January this year, he explains his reasons for purchasing the system and how it helps him with the new pharmacy contact

Chan qualified in pharmacy at Brighton in 1988 and completed his pre-registration with Boots the Chemists. He purchased his pharmacy in 1989 shortly after completing his pharmacy degree and has recently incorporated a consultation room in the pharmacy to take advantage of the new services coming on line...

Why did you purchase a Healthpoint?
"I first read about Healthpoint in the Chemist and Druggist last year and realised this system was something I had been looking for. Under the requirements of the new pharmacy contract we now have to provide healthcare information, signposting and healthy-lifestyle advice that we help the patient better their wellbeing. The Healthpoint fulfils all these functions and gives added 'weight' to my advice as a pharmacist."

How else does Healthpoint help with the new contract?
"We have found it to be extremely useful in our medication use reviews, which we are accredited for, particularly when dealing with asthmatics. The use of the educational videos on asthma helps ensure a quality outcome in our reviews and the fact that the patient can take away the advice is another added benefit. What I like about the Healthpoint system is that it is very much about how a pharmacist can help a patient."

Are there other areas that Healthpoint provides assistance?
"I find it very useful for EHC – the advice provided is excellent and extremely relevant. Other reasons for having a Healthpoint are the advice on herbal medicine and homeopathy. Having a homeopathic hospital in town means we are often asked to give advice on these approaches to health management. Having the Healthpoint here with its large range of information on both subjects is invaluable. The drug interactions on herbs are excellent. Furthermore, we are a busy pharmacy and the Healthpoint provides fast, accurate and comprehensive information and advice on a vast number of subjects."

Nine months into the contract what is your view on how it is unfolding?
"Overall I believe the contract is fundamentally right. The pharmacist's role was becoming marginalized and if we did not accept and embrace change we were ultimately doomed. I am excited about the opportunities we now have with the new services – we have a second pharmacist to make sure we are ready. We recently started MUR's and will provide any services that the PCT wishes to provide. This coupled with other services we wish to provide will represent a real new age of pharmacy."

Are you concerned about funding for the advanced and enhanced services?
"Funding is always a concern, however, if you do not provide these services you will be unable to influence the future direction. This is a starting point and from here we will move forward. It is a huge learning curve for all concerned – patient, pharmacist and the PCT. My view is that we have to move in this direction."

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TECHNOLOGIES

Three pharmacists from different parts of the country describe to *C&D* the different ways they have achieved patient safety success

"It didn't take us long to realise there was a lot of potential for error because it was so busy"

Jonathan Burton, Danderhill Pharmacy, Dalkieth

Jonathan Burton was awarded the Almus patient safety award in November for his scheme to make dispensing safety a priority in his pharmacies.

Mr Burton introduced a 'traffic light' system of error reporting into the three pharmacies for which he acts as superintendent. Red forms are filled in by pharmacy staff to record errors, yellow for near misses and green for potential errors.

The errors are reviewed and form the basis of staff newsletters, which address problems, keep staff up to date with standard operations and explain procedures. For particular problem areas a training pack is created to sit alongside NPA dispensing assistant course training.

Mr Burton realised the importance of dispensing safety when he bought his second, small pharmacy. "It didn't take us long to realise there was a lot of potential for error because it was so busy," he said.

Since introducing the system Mr Burton says actual errors have dropped by around 50 per cent. The most difficult part of the system is convincing staff that admitting errors is "not about blame", he says. However, with reassurance their attitudes have changed and reporting allows error trends to be identified and to see how things can be changed.

"I've used other error reporting systems in different pharmacies and felt they were stale," he says. "These coloured forms make reporting easier, they are designed to be quick to fill out."

Mr Burton says many errors can be avoided by ensuring dispensaries are kept tidy, talking to staff about danger areas and encouraging them to check their work. "Packing is often a habit so visual reminders don't often make much difference. It's more about education and doing a self-check."

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David Winton, Cadge Pharmacy, Tottenham

"If someone asks what a particular drug is by describing it, we often don't know"

Discovering LED message displays while on a trip to Los Angeles in December gave David Winton the idea to use the screens in his pharmacy to improve safety.

The mini screens are attached to prescriptions and used to display alerts or warnings to staff. The screens also flash to remind staff to complete other tasks before dispensing, such as ensuring patients pay for their prescriptions.

Safety-conscious Mr Winton has not stopped there. He has come up with a number of ideas to improve safety in his pharmacy, including the idea for a diagram of actual tablets to be included on the packaging of Almus drugs.

"We do a lot of unit dosage and if someone asks what a particular

drug is by describing it, we often don't know what it is," he says. "We can ring the NPA for information, but it's easier if the packaging comes with a diagram of the tablet to let us recognise what people are describing."

Mr Winton says tablet identification is a lifesaver, as it is easy to make mistakes. "Once tablets are removed from their packaging it's difficult to spot errors and it's difficult for patients to identify tablets."

Mr Winton has more ideas for improving safety by introducing more machines in his pharmacy to provide accurate measures of liquid drugs.

"I'm a gadget fanatic," he says. "We've got to move on with more modern pieces of equipment that can enhance pharmacy and improve safety."

Chris Martin,

Crymych Pharmacy, Pembrokeshire

"We work as a team in the dispensary and we have encouraged a no-blame culture"

Chris Martin has established a near miss audit in his pharmacy to help identify problem areas and improve safety measures.

Supported by Pembrokeshire Local Health Board, the audit has been rolled out across the region to allow pharmacies to share their tips for best practice.

Pharmacy staff have been encouraged to identify areas with potential for near misses in the dispensary, as well as recording when dispensing errors or near misses have occurred.

Mr Martin says the system, which has been running for 18 months, has been very well received by pharmacy staff. "We work as a team in the dispensary and we have encouraged a no-blame culture," he says. "It's been made very clear to staff that it's about working together to improve safety.

"The audit allows us to improve safety measures in pharmacy and give better services to customers, not just in our pharmacy but across the pharmacies in Pembrokeshire."

Safety improvements to the pharmacy include putting stickers on shelves to warn staff about the dangers of certain drugs and encouraging staff to check strengths and dosage.

The audit was developed after Pembrokeshire Pharmacy Forum received funding from the clinical governance sub-group to set up the project. Other pharmacies enrolled in a pilot for the NPSA to identify near misses and the audit has grown across pharmacies in the region.

"It began as a project but that good practice is there and instilled in all pharmacies in Pembrokeshire," Mr Martin adds. "Incidents have reduced significantly and people have become more aware of safety issues, so it's a win-win situation."

He says pharmacies should encourage staff to do near miss audits, learn from their experiences and share near misses and tips for overcoming them with colleagues and other pharmacies. "It's about encouraging team work and creating a no blame culture," he says. "We're all human and we can all make mistakes, we just need to make sure we learn from them."

Advertisement feature

SKIN TIPS

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Appointments

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The Scottish Pharmaceutical General Council (SPGC) represents the interests of over 1140 pharmacy contractors in Scotland. As we move towards implementation of the policy document, 'The Right Medicine', we require a dynamic Chief Executive to lead and develop the organisation at an exciting and challenging time. As the body recognised by the Scottish Executive as a representative of community pharmacy contractors, it is our responsibility to negotiate a new contract for our members, against the backdrop of a changing and modernising NHS in Scotland.

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The role:

- Reporting to the Standing Committee of the SPGC. Responsible for developing and delivering the strategic vision for the SPGC while managing the organisation on a day-to-day basis. Focus on developing an effective business and change strategy.
- Strengthening relationships with members and key external stakeholders such as NHS Scotland, MSPs, media
- Key member of negotiating team for the new community pharmacy contract
- Overall policy, budgetary, HR, risk management and IT responsibility
- Raising the profile of the SPGC in key target areas

The qualifications:

- Educated to degree or equivalent level
- Demonstrable leadership qualities with highly developed influencing and negotiating ability and prior experience of dealing at board/senior management level
- Strong people management, planning and communication skills and a clear commitment to maintaining the highest levels of integrity and quality of service
- Successful track record of delivering change, possibly in a health or business environment
- Experience of the NHS and/or pharmaceutical profession is not essential, but may be helpful

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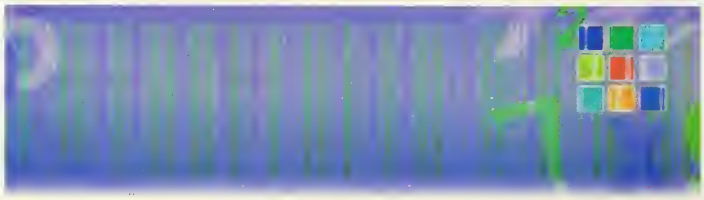

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Back ISSUES

A dream of a pill

How would you like to have more dreams when you are asleep and a better memory when you are awake? You could spend the night with Angelina Jolie or George Clooney (in your dreams) and then remember enough about it to tell all your friends the next day.

Swiss company Actelion believes it has the solution: a new sleeping pill that not only induces sleep, but also increases the dream phase, consolidating memory and improving one's sense of wellbeing.

Studies showed rats given Actelion's drug orexin-RA-1 slept soundly and performed better in maze tests the following day than rats given conventional sleeping medications. Unfortunately, they don't mention whether it will help patients with that other nocturnal bugbear - trying to block out the unwanted sound of snoring partners.

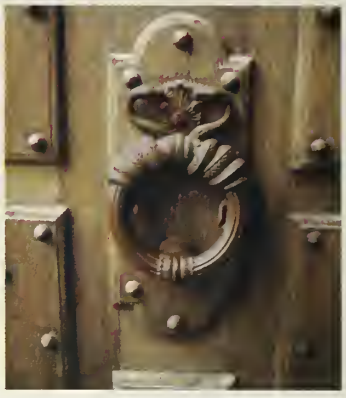
Weed the instructions carefully

The Netherlands' first pharmacy dedicated to providing high-quality cannabis for pain relief is set to open in the northern town of Gröningen.

While cannabis is available in Dutch coffee shops, patient support group the foundation for Medicinal Cannabis Netherlands plans to launch a pharmacy to sell cannabis for medical use.

A Gröningen city councillor who supports the plan said while cannabis may be cheaper in coffee shops, it is often poorer quality.

Plans for the cannabis pharmacy have been backed by residents and local police. Two more cannabis pharmacies are planned in other towns across the country.



Closing the door on flu

If you're worried about flu spreading around your pharmacy, maybe you should invest in some copper doorknobs.

Scientists at Southampton University wiped a common flu virus on copper and stainless steel. They found the virus died six times faster when wiped on copper, and had disappeared within six hours. Half of the virus wiped on the stainless steel was still alive after six hours.

Researchers said in light of the avian flu threat, healthcare premises should consider changing frequently touched surfaces such as doorknobs, handles and counter surfaces to copper to help control the spread of infection.

Appointments

David Atkinson has been appointed as a business development manager with United Co-op Healthcare. Mr Atkinson, who will be responsible for the performance of 70 pharmacies in United's northern region, previously worked for SA Sheard in Leeds which was acquired by United in 2005.

David Atkinson

Adrian Hennah has been appointed as Smith & Nephew's new finance director from June. Mr Hennah, who is currently chief financial officer of Invensys, will replace Peter Hooley who is retiring after 15 years in the position.

Jill Chiwara

SkyePharma has appointed **Argeris Karabelas** as its new non-executive chairman. Dr Karabelas, previously chief executive of Novartis Pharma, has been a non-executive director of SkyePharma since 2000.

The company also announced the appointment of **Frank Condella** as chief executive and **Ken Cunningham** as chief operating officer. Mr Condella was president of the European operations of IVAX prior to its acquisition by Teva while Dr Cunningham was chief executive of Arakis.

Jill Chiwara has taken up the position of Scottish services development co-ordinator to help Numark members in Scotland through the intricacies of the new pharmacy contract. Ms Chiwara has a pharmacy degree from Robert Gordon's in Aberdeen. She joins Numark from Phoenix, where she was area manager for three years.

A Wolverhampton family will carry on working together at their Low Hill pharmacy following its acquisition by the Midcounties Co-op. John Whitmore, chairman of the Wolverhampton Local Pharmaceutical Committee, has owned the branch for 13 years. Pictured are John (centre) alongside his wife Isobel (left) and daughter Eleanor, who is an accredited checking technician

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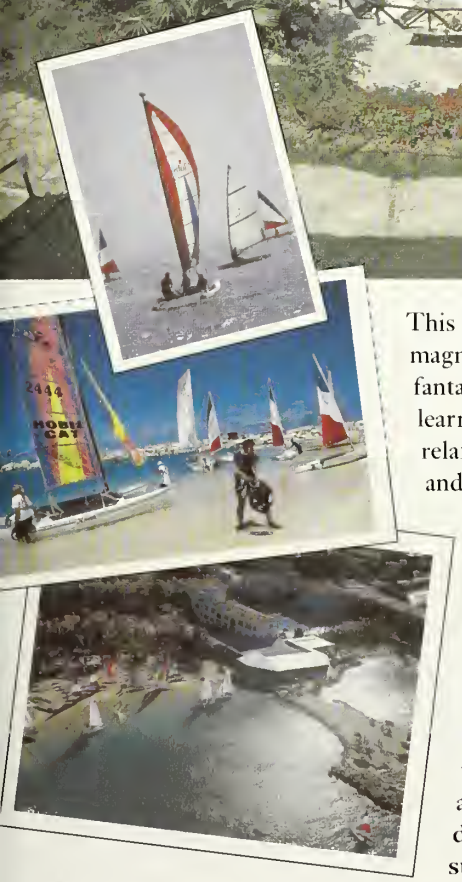

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Rules 1.This competition is open to any pharmacist or permanent member of staff who works at an address which receives either *C&D* or Community Pharmacy 2.Competitors may enter through *C&D* or Community Pharmacy, but may only submit one entry. Double entry will disqualify both entries 3.Entries must be on an original coupon from *C&D* or Community Pharmacy, and to be eligible for the prize entrants must correctly answer the question on the coupon 4.The prize offered will be as stated. No alternative holidays or cash prizes will be offered 5.Names of winners will be published in *C&D* and Community Pharmacy 6 In any dispute, the decision of CMP Information Pharmacy Group's publishing director will be final and no correspondence will be entered into 7.Employees of CMP Information Ltd, Holidaysaver and trading divisions and their immediate families are forbidden to enter 8.No purchase is necessary to participate 9.The closing date for this month's competition is as printed on the entry coupon

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